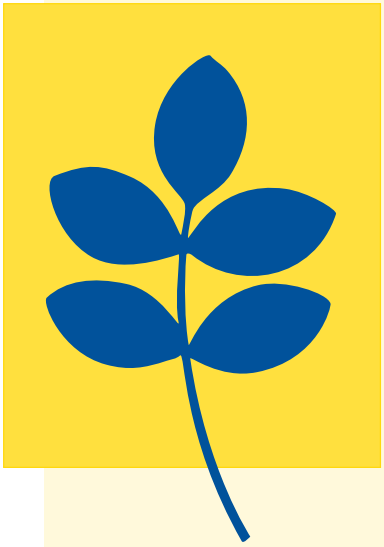

2002

Basic Health Member Handbook

HCA 22-405 (1/02)

Health Plan Phone Numbers and Web Sites

	Customer Service Hours:	Customer Service Phone Numbers:	Web Site Address:
Aetna U.S. Healthcare of Washington, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-654-6506 or 206-701-1100 TTY: 1-877-580-5017	aetnaushc.com
Columbia United Providers, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-315-7862 or 360-891-1520 TDD: 1-866-287-9962	Pending at time of publication
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-440-1561 or 206-521-8830 TTY: 1-800-833-6388	www.chpw.org
Group Health Cooperative of Puget Sound	Mon. – Fri. 7:30 a.m. – 6 p.m.	1-888-901-4636	www.ghc.org
Kaiser Foundation Health Plan of the Northwest	Mon. – Fri. 8 a.m. – 7 p.m.	1-800-813-2000 TTY: 1-800-324-8007	www.kp.org
Molina Healthcare of Washington, Inc.	Mon. – Fri. 7:30 a.m. – 6 p.m.	1-800-869-7165	www.molinahealthcare.com
Premera Blue Cross	Mon. – Thurs. 8 a.m. – 5 p.m. Fri. 8:30 a.m. – 5 p.m.	1-800-691-3072 TTY: 1-800-842-5357	www.premera.com
Regence BlueShield	Mon. – Fri. 7:30 a.m. – 5 p.m.	1-800-560-5731	www.regence.com

Washington "Hotline" Phone Numbers

Alcohol and Substance Abuse 1-800-562-1240

Domestic Violence 1-800-562-6025

Emergency Contraceptive Advice 1-888-NOT-2-LATE (1-888-668-2528)

Family Planning 1-800-770-4334

HIV/AIDS (National) 1-800-342-AIDS (1-800-342-2437)

Poison Control 1-800-732-6985

If you have any questions about…	Call…
• **Adding and/or dropping a family member** • **Address changes** • **Income changes** • **Premium amount**	Basic Health toll-free at: 1-800-842-7712 to request forms or to hear recorded information; or 1-800-660-9840 to talk to a Basic Health benefits specialist.
• **Bills received for services** • **Choosing a primary care provider** • **Covered services** • **Services received from providers** • **Waiting periods**	Your health plan. (See the phone number on the inside cover of this handbook.)
• **Your medical care** • **Referrals to specialists**	Your primary care provider.
• **Premiums, payments, billing, or refunds**	Basic Health toll-free at: 1-800-842-7712 for 24-hour, self-service verification of premium payment information; or 1-800-660-9840, then follow the recorded instructions to speak with an accounting representative.

When you call or write us…

Be sure to include your **name**, **subscriber I.D. number**, **address**, and a **daytime phone number**.

If you speak with a representative, it is helpful if you note the date of the call, whether the representative was with Basic Health or your health plan, and the name of the person you talked to. If you are enrolled as part of an employer, home care agency, or financial sponsor group, first contact your group representative (usually your payroll officer or financial sponsor representative). He or she may have the information you need, or may need to know about a change you're reporting.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Si desea ayuda en español, llame al 1-800-321-0291.

Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.

한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오.

Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

At A Glance

Basic Health office hours ..... Monday through Friday, 7:30 a.m. until 5:30 p.m.

Mailing addresses

Premium payments (with payment stub only) ..... P.O. Box 34270, Seattle, WA 98124-1270

General correspondence ..... P.O. Box 42683, Olympia, WA 98504-2683

Basic Health appeals (see pages 20-21 first) ..... P.O. Box 42690, Olympia, WA 98504-2690

Basic Health Web site .....www.wa.gov/hca/basichealth.htm
(Includes provider directory, *How Much Will Basic Health Coverage Cost?*, and other useful information)

Family additions (report new family members even if not enrolling them)

If you are adding (a):	*Application form must be received by Basic Health:*
Newborn	Within 60 days of birth
Newly adopted child	Within 60 days of placement for adoption
Other child	Within 30 days of marriage or custody change
New spouse	Within 30 days of marriage
Yourself or an eligible family member due to loss of other coverage	Within 30 days of loss

If you are pregnant .....Notify Basic Health immediately (see page 17)

Other account changes

Income change ..... Notify Basic Health if any source of income increases or decreases enough to change your income band (as shown in the *How Much Will Basic Health Coverage Cost?* brochure). **You are required to report the income change no more than 30 days after the end of the first month at the new income level.** See important information on pages 6 and 10.

Address change .....Use the *Change Form* included with your monthly billing statement

Premiums

Premium due date ..... 5th of each month (pays for the following month of coverage)

Basic Health's full-premium program ..... See pages 24-25

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(continued on next page)

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CHAPTER ONE: Introduction

What is Basic Health?

Basic Health offers high-quality, affordable health coverage to eligible Washington State residents. Basic Health is a state program administered by the Washington State Health Care Authority (HCA). The HCA contracts with health plans to offer Basic Health and Basic Health *Plus* to eligible Washington State residents. Each health plan, in turn, contracts with hospitals, clinics, pharmacies, physicians, and other providers to form that health plan's network of providers who deliver health services to Basic Health and Basic Health *Plus* members. For some Basic Health *Plus* and Maternity Benefits Program services, such as dental and vision care, the state pays the provider directly.

As a Basic Health member, your monthly premiums are based on your (and your dependents') age, family size, income, and the health plan you choose. If your income increases, you may pay a higher percentage (up to the full cost) of your premium and, in some cases, you may be disenrolled or transferred to Basic Health's full-premium program. For more information on income guidelines, refer to *How Much Will Basic Health Coverage Cost?* on our Web site or call 1-800-660-9840.

You must follow your health plan's guidelines and procedures to receive the benefits described in this handbook. You may also be required to provide your health plan or Basic Health with information (including medical records) needed to determine eligibility for benefits or to process claims. Guidelines and procedures may vary from health plan to health plan. Be sure to read your health plan's materials for details and call your health plan first if you have any questions about benefits.

How do I use this handbook?

This handbook serves as your certificate of coverage. It describes the services and supplies covered by Basic Health, and the rules you must follow when using this coverage. This handbook is subject to the administrative rules of Basic Health, chapter 182-25 of the Washington Administrative Code (WAC), as amended.

Keep your *Member Handbook* in a convenient place and refer to it whenever you have a question about your benefits. We've provided some handy resources, including forms for reporting income changes and a list of phone numbers in case you have questions not answered here.

Basic Health sometimes sends publications such as *Hot Policy Pages*, open enrollment information, or other notices to keep you informed and notify you of changes. These may include amendments to the information in this handbook. You should keep these publications with your *Member Handbook* for future reference.

For the most part, this handbook is written for all members of Basic Health. However, additional information for the Maternity Benefits Program and Basic Health *Plus*, and for members of Basic Health for Groups, will be contained at the end of many sections. If you're a member of one of these programs, look for the identifier as shown below:

- **+** Basic Health *Plus*
- **M** Maternity Benefits Program, or
- **G** Groups

Throughout this handbook, "you" generally refers to the main subscriber on your Basic Health account. In Basic Health *Plus* sections, "you" generally refers to an adult who will be reading and referring to Basic Health *Plus* coverage on behalf of his or her children.

Full-premium members

If you're enrolled in Basic Health's full-premium program, see pages 24-25 for specific details. Sections that have been amended are marked. See pages 2 and 3 for more information on the various Basic Health programs.

CHAPTER TWO:
How Does Basic Health Work?

Who is eligible for Basic Health coverage?

Basic Health is available to any Washington resident who:

- Meets income guidelines;
- Is not eligible for Medicare; and
- Is not institutionalized (at the time of enrollment) in a government-funded facility that has historically provided health care.

You are considered "eligible" for Medicare if you are eligible for free Medicare coverage or are eligible to buy Medicare coverage.

Family members who should be listed as dependents on your account include your:

- Spouse (unless legally separated).
- Unmarried children including stepchildren; legally adopted children; and children placed in your home for purposes of adoption, or other children for whom you provide documentation of legal guardianship (such as a copy of a court order); who are:
  - Under age 19; or
  - Under age 23, if full-time students at an accredited school.
- Legal dependents of any age, who are not capable of self-support due to disability. You must provide documentation of legal guardianship, such as a copy of a court order.

Family members who are not eligible for coverage on your account may be eligible to enroll separately—for example, a child who reaches age 19 and is not disabled or attending school full time. To apply for Basic Health coverage, this child must complete a separate application and enroll under his/her own account.

BASIC HEALTH *PLUS*

Basic Health *Plus* is a Medicaid program for children under age 19; it's run by Basic Health and the Department of Social and Health Services' Medical Assistance Administration, which will be referred to as "DSHS" throughout the rest of this handbook. With Basic Health *Plus*, eligible children receive additional health care coverage such as dental care, vision care, and physical therapy at no cost to you. Medicaid pays the entire cost for Basic Health *Plus* coverage, including monthly premiums and copayments. Children enrolled in Basic Health *Plus* will receive services through the same health plan that provides your Basic Health coverage.

Your children may be eligible for Basic Health *Plus* if you meet Basic Health income guidelines. To be eligible, the children must be your legal dependents, live in your home, and be:

- Under age 19;
- U.S. citizens, or immigrants who arrived in the U.S. on or before August 22, 1996;
- Not enrolled in any other managed care plan, including TRICARE; and
- Not receiving Temporary Assistance for Needy Families (TANF) grants from DSHS.

If you would like to transfer your child's coverage from Basic Health to Basic Health *Plus*, call 1-800-842-7712 for an application.

BASIC HEALTH FOR GROUPS

In addition to individual coverage, Basic Health is available to groups. Employers, home care agencies, and financial sponsors may enroll their employees or sponsored members in a Basic Health group account. If you are covered through a group account, your employer or financial sponsor pays your

premium, but may collect part of it from you. Under group membership, your main contact with Basic Health will be through your group representative.

Basic Health for foster parents and personal care workers

If you are currently licensed by DSHS as a foster parent or under contract with DSHS as a personal care worker, and your income qualifies you for a reduced premium, you may be able to pay an even lower premium for Basic Health coverage. For further information or to request a foster parent or personal care worker application packet, call 1-800-660-9840 or check Basic Health's Web site. To apply for this lower premium, complete the *Certification Form* in the packet and return it to Basic Health, along with the requested documentation.

How the health plans work

Costs, providers and facilities, covered prescription drugs, referral practices, and other guidelines may differ by health plan. However, all the health plans offer the same basic benefit package and require you to choose a primary care provider (PCP) to coordinate or provide your care.

Each health plan contracts with a number of providers and facilities (called the health plan's "provider network"). Your health plan may refer you to a specialist or facility outside the health plan's network if you or your child needs a provider or hospital not available in your health plan's network. You must get your health plan's approval to be treated by a provider or facility not available through your health plan's provider network, except in an emergency (see page 17).

Some health plans may contract with provider groups called subnetworks; **this may restrict your choice of providers.** You may be required to see specialists or use facilities, such as hospitals, which are in the same subnetwork as your PCP. This means that, even if a provider is affiliated with your health plan, the provider's services may not be available to you unless the provider is also affiliated with your PCP.

Call the health plan or your PCP to find out if your PCP can refer you to anyone listed as a provider with that health plan, or if your PCP can refer you to only a selected group of providers within the health plan.

Basic Health *Plus* and Maternity Benefits Program

If you or your dependent are enrolled in Basic Health *Plus* or the Maternity Benefits program and you would like to know more information regarding the Physician Incentive Program (PIP), please call your health plan.

Your primary care provider

Each covered family member must enroll in the same health plan, but may choose a different primary care provider (PCP) within that health plan. Except in an emergency, your primary care provider and staff will provide or coordinate all of your health care needs, including referrals to specialists. Primary care providers may be family or general practitioners, internists, pediatricians, or other providers approved by your health plan. You may change your PCP during the year. Contact your health plan for details on changing providers or for a current list of providers. You may also contact the provider you're considering and ask if he or she contracts with your health plan for Basic Health coverage. When you call a provider, be sure to mention the health plan name and Basic Health, and ask whether the provider participates in the health plan.

To be covered by your health plan, all health services must be provided by your PCP, unless:

- You are referred by your primary care provider (in most cases, the referral must be approved by your health plan); or

- You need emergency care, as described on page 17; or
- You self-refer for women's health care services or covered chiropractic care to a provider who contracts with your health plan.

If you have questions, call your health plan at the number listed on the inside cover of this handbook.

Dependent temporarily out of county/state

If your dependent child is temporarily away at school (or lives away from you part of the time), he or she may still be covered under Basic Health as long as he or she maintains Washington State residency. If possible, select a health plan that provides service to both your home county and the county in which your child is located. Otherwise, Basic Health will cover only emergency care while your child is out-of-state or staying in a county that is not served by your health plan. Any routine services for that child should be scheduled for a time when he or she is home from school. When necessary, Basic Health allows your dependents to enroll in a different health plan under a separate account so that your dependent may receive services within the county where he or she lives. There will be a separate billing for that account.

Basic Health *Plus*

If you cannot drive your child to a health care provider for covered services, call the DSHS transportation broker for your region. Call Medical Assistance Customer Service at 1-800-562-3022 for the transportation broker's phone number. Make sure you have your child's DSHS Medical Assistance I.D. (M.A.I.D.) card and Basic Health *Plus* I.D. card handy when you call.

Self-referral for women's health care services

Female members may seek care for women's health care services without a PCP referral or health plan preauthorization. **You may seek these services from any women's health care provider who contracts with your health plan. Facility services such as those provided by hospitals or outpatient surgical centers may require preauthorization from your health plan.** The following women's health care services are covered under this benefit:

- Maternity care, including prenatal, delivery, and postnatal care.
- Routine gynecological exams.
- Except as specifically excluded, examination and treatment of disorders of the female reproductive system.
- Other health problems discovered and treated during the course of a woman's health care visit, as long as the treatment is within the provider's scope of practice, and the service provided is not excluded.

Any follow-up services for conditions not directly related to maternity care, routine gynecological exams, or disorders of the female reproductive system may require referral and preauthorization by your health plan.

Please note: Women who use the self-referral option may only choose providers who contract with their health plan to provide Basic Health services. You must obtain preauthorization or approval from your health plan if your women's health care provider refers you to another specialist, and your health plan may require preauthorization for any services provided to you by a facility. **Benefits may be denied if you do not follow your health plan's referral and preauthorization requirements.** Please call your health plan for information.

When will my coverage begin?

Basic Health will notify you in writing when your Basic Health or Basic Health *Plus* managed care coverage is effective. It generally takes four to six weeks to process your application once all information is received. Basic Health's reduced-premium program can enroll only a limited number of people. If we reach that limit, Basic Health will delay your coverage. **Please note:** Even if your payment has been processed, your coverage will not begin until after your application has been approved and space is available.

If you marry and you follow the procedures explained in "Family Changes" on page 12, coverage for your new spouse (and stepchildren, if any) will begin on the first day of the month after the enrollment process is complete.

Your newborn (or adopted) child is covered from the date of birth (or placement in your home) if you or a family member are enrolled in Basic Health or Basic Health *Plus*, but only if Basic Health receives your application to enroll the child within 60 days of the birth (or placement). Refer to page 12 for instructions on applying for coverage for a new family member.

If you want to stop Basic Health coverage, see "How to disenroll" on page 14.

Basic Health *Plus* and Maternity Benefits Program

If you or your dependent are enrolled in Basic Health while eligibility is being determined for Basic Health *Plus* or the Maternity Benefits Program, you are charged a premium for that person. If enrollment in Basic Health *Plus* or the Maternity Benefits Program (managed care) is approved for a month for which you have already paid Basic Health premiums, the overpayments will be credited to your account for future months. However, Basic Health premiums will not be credited for months you were covered under DSHS fee-for-service.

Identification cards

After your enrollment in Basic Health, the health plan will send you and your enrolled family members a Basic Health I.D. card. (Some health plans may require that you choose a PCP before they will issue your I.D. card.) The card has important information, including the number to call if you are hospitalized or have questions. If you need care before you receive the card, contact the health plan at the number listed on the inside cover of this handbook. Your enrollment confirmation letter from Basic Health can serve as temporary identification before you receive your card.

Basic Health *Plus* and Maternity Benefits Program

You receive two I.D. cards for each member enrolled in Basic Health *Plus* or the Maternity Benefits Program:

- A Basic Health I.D. card.
- A DSHS Medical Assistance I.D. (M.A.I.D.) card, allowing the member to receive additional Medicaid covered services. You receive a new card each month.

You or your dependent should carry both cards.

Premium payments

Your premiums are due the fifth of the month before the month of coverage; the amount and due date are shown on each month's billing statement. You are sent a statement for coverage approximately six weeks before the month covered by that payment. For example, your statement for August coverage is sent mid-June and your premium is due July 5.

If you do not pay the entire premium on time, your statement for the next month will include a delinquency notice. Your payment for the total amount shown must be received by Basic Health by the due date given on the notice, or your coverage will be suspended for one month. Partial payment, or checks returned for non-sufficient funds or missing signature, will be considered nonpayment and may also result in your suspension or disenrollment.

If your coverage is suspended, your health plan will not pay for any health care services you or your family members receive during that month. Basic Health will send you a notice of suspension, which will tell you the month you will be without coverage and will include a due date for payment if you want to return to Basic Health coverage. If you pay the amount due by that due date, your coverage will be restored on the first day of the following month (you will be without coverage for one month). If your payment is not received by Basic Health by the due date on the suspension notice, you and your family members will be disenrolled from Basic Health and will not be allowed to re-enroll for at least 12 months.

In addition, if your coverage is suspended more than two times in a 12-month period, you and your family members will be disenrolled from Basic Health and will not be allowed to re-enroll for at least 12 months.

Please note: Coverage will continue for any family members enrolled through DSHS Medical Assistance programs (Basic Health *Plus* or the Maternity Benefits Program) as long as they remain eligible for these programs.

Basic Health for Groups

As a member of a group, your employer, home care agency, or financial sponsor will pay your premium, but may collect part of it from you.

If your employer, home care agency, or financial sponsor doesn't pay the premium on time, you may be disenrolled from Basic Health group coverage. If your group is disenrolled, Basic Health will offer you coverage under an individual account, but you may have a period of time without coverage.

Recertification

State law requires Basic Health to periodically verify that our members' income and eligibility information is up to date. Under this "recertification" process, Basic Health subscribers receive a letter requesting copies of their current income and other relevant documentation. Being selected for recertification does not mean that Basic Health believes you have given us the wrong information, but it is a legal requirement.

If you receive this letter, you must send Basic Health all the documentation requested by the due date given. **If you do not send all information requested**, and we cannot verify your continued eligibility for Basic Health, you will be disenrolled and may not re-enroll for at least 12 months. **If you do not send complete income documentation**, we cannot verify your continued eligibility for a reduced premium and, because enrollment in the full-premium program is limited, you may be disenrolled. If you are determined eligible to continue coverage in the full-premium program, and full-premium enrollment is available in your area, you may continue coverage by paying the full cost of your premium. Your copayment responsibilities will change if you are transferred to the full-premium program. See page 25 for specific information regarding full-premium copayments and maternity care. If you were disenrolled because we were unable to verify your continued eligibility for a reduced premium, and our

full-premium program was not available in your area, you may return to Basic Health's reduced-premium program after we receive the required documentation; however, your enrollment may be delayed if space is not available.

Recoupment

Important: You must notify Basic Health right away if your income increases enough to move you to a different income band. Basic Health may verify your income through contact with other state or federal agencies. If this shows that you have not reported an income increase which affects your premium, Basic Health may bill you for additional premiums due for past months (called "recoupment"). Washington State law also allows Basic Health to collect a penalty of up to 200 percent of the amount due.

If you had an increase in income and are billed for past premiums, you may be disenrolled unless you pay the amount due, according to the billing schedule established by Basic Health. If you are disenrolled under these circumstances, you will not be allowed to re-enroll for at least 12 months **and** until your account balance is paid. Also, your account will be referred to a collection agency; you will be responsible for any fees or charges associated with the collection proceedings, as well as the full balance due on your account.

Rights and responsibilities

As a Basic Health or Basic Health *Plus* member, you and your enrolled dependents have the right to:

- Understand Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.
- Get readable, understandable notices or have the materials explained or interpreted.
- Receive timely information about your health plan.
- Get courteous, prompt answers from your health plan and Basic Health.
- Be treated with respect, dignity, and a right to privacy by Basic Health, Basic Health *Plus*, and Maternity Benefits Program providers.
- Obtain information about all medical services covered by Basic Health, Basic Health *Plus*, and DSHS Medical Assistance.
- Choose your health plan and primary care provider.
- Receive proper medical care without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, or religion, consistent with Appendices A and B of this handbook.
- Get all medically necessary covered services and supplies listed in the Basic Health or Basic Health *Plus* Schedule of Benefits, subject to the limits, exclusions, and copayments described in Appendices A and B, or, if you're a full-premium member, in Chapter Six of this *Member Handbook*.
- Participate in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage.
- Get medical care without a long delay.
- Refuse treatment and be told of the possible results of refusing.
- Expect your and your child's records or conversations with providers to be kept confidential.
- Obtain a second opinion by another health plan provider when you disagree with the initial provider's recommended treatment plan.
- Make a complaint about the health plan or providers and receive a timely answer.
- File an appeal with your health plan, DSHS, or Basic Health if you are dissatisfied with a decision (please refer to pages 21-23).

- Receive a review of a Basic Health appeal decision, if you disagree with it.
- Receive a fair hearing from DSHS, regardless of whether you filed an appeal with your health plan (Basic Health *Plus* and Maternity Benefits Program only).
- Change your primary care provider for a good reason (call your health plan for assistance).

As a Basic Health or Basic Health *Plus* member, you and/or your dependent have the responsibility to:

- Report changes of address, family status, or income when they happen by submitting appropriate forms or calling Basic Health at 1-800-660-9840.
- Select one of the health plans available in your area.
- Select a primary care provider from your health plan before receiving services.
- Cooperate with your health plan and DSHS to help obtain any third party payments for medical care.
- Report to your health plan any outside sources of health care coverage or payment, such as insurance coverage for an accident.
- Inform your or your child's primary care provider of medical problems and ask questions about things you do not understand.
- Decide whether to receive a treatment, procedure, or service.
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral.
- Get a referral from the primary care provider before you go, or take your child, to a specialist.
- Pay Basic Health copayments in full at the time of service (applies only to Basic Health members).
- Pay your Basic Health premiums in full by the date they are due (applies only to Basic Health members).
- Not engage in fraud or abuse in dealing with Basic Health, Basic Health *Plus*, DSHS, your health plan, your primary care provider, or other providers.
- Keep appointments and be on time, or call the provider's office when you or your child are going to be late or can't keep the appointment.
- Keep the DSHS M.A.I.D. card (Basic Health *Plus* and Maternity Benefits Program members only) and Basic Health I.D. card with you or your child at all times.
- Notify the health plan or primary care provider within 24 hours or as soon as is reasonably possible of any emergency if services have been provided outside the health plan.
- Use only your selected health plan and primary care provider to coordinate services for your family's medical needs.
- Comply with requests for information, such as previous medical records or other coverage, by the date requested.
- Submit updated proof of eligibility when requested.
- Cooperate with your primary care provider and referred providers by following recommended procedures or treatment.
- Work with your health plan and providers to learn how to stay healthy.

Basic Health *Plus* and Maternity Benefits Program

Along with the rights and responsibilities shown above, members of Basic Health *Plus* and the Maternity Benefits Program also have the right to:

- Have language interpreters and interpreters for deaf and hearing-impaired, if necessary, during medical appointments, when talking with the health plan providers and administrators, and during a fair hearing or review of a complaint.
- Enrollees shall have the right to change enrollment prospectively, from one health plan to another without cause, each month.

Informed Consent

You have the right to give your consent. You have the right to know about the possible side effects of your care and give your consent before you get care. Be sure to ask your provider about the side effects of your care.

Advance Directives

Advance Directives put your choices into writing. They may also name someone to speak for you if you are not able to speak. Washington State law has two kinds of Advance Directives:

1. Durable Power of Attorney for Health Care – This names another person to make medical decisions for you if you are not able to make them for yourself.
2. A Directive to Physicians (Living Will) – A statement that you want to die naturally and don't wish to have treatments that will prolong your life.

Account privacy

Without your written authorization, the Health Care Authority cannot release personal account details such as eligibility, enrollment, monthly premium, or payment to anyone but you or your health plan.

Exceptions:

- If you are enrolling as part of an employer, home care agency, or financial sponsor group, limited information may be released to your group representative. Ask your group representative for details.
- Information about a minor child will be released to either parent.
- If you are applying for or enrolling in Basic Health *Plus* or the Maternity Benefits Program, or as a foster parent, personal care worker, or home care worker, some information may be shared with DSHS.

If you want to let someone else, such as a friend or relative who is helping you, access your account details, you'll need to send written authorization to Basic Health. Be sure to sign and date your letter and include the person's name, their relationship to you, and what information you want released to them. Only the information you specify will be released, so if you want to give this person access to all your account information, you will have to specifically state that they can have access to all account information. You will also need to specify if this permission is being granted for a specific time period or for as long as you remain enrolled in Basic Health. When this person calls, they'll need your Basic Health subscriber I.D. number, and will be asked for other identifying information.

Chapter Three: Making Changes

How to make changes to your account

To make some types of account changes or to request forms, use the detachable *Change Form* included with your billing statement. We have also included the forms for reporting income changes at the back of this handbook. To request additional forms for account changes, you may call our 24-hour, automated, self-service phone line, 1-800-842-7712 or visit our Web site. You may also write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683.

Income changes

(Full-premium members: Please refer to page 24.)

If your income or family size changes, your monthly premium may change, too. If your family income increases enough to affect your premium, you are required to report the income change to Basic Health within 30 days of the end of the first month. Be sure to also notify Basic Health if your income decreases or if you are no longer receiving income you previously reported. After your income changes, you will need to continue paying your premium as billed until we notify you of the new premium amount. (See additional information under "Recertification" on pages 6 and 7 and "Recoupment" on page 7.)

Basic Health uses federal income guidelines to help determine eligibility and monthly premiums for our reduced-premium program. Below are Basic Health's income bands, in effect until July 1, 2002. All Basic Health members will receive a *Hot Policy Page* in May 2002, which will amend the income bands printed here.

Family Size							Income Bands
1	2	3	4	5	6	7	
$0 – $465.29	$0 – $628.87	$0 – $792.45	$0 – $956.04	$0 – $1,119.62	$0 – $1,283.20	$0 – $1,446.79	A
465.30 – 715.83	628.88 – 967.49	792.46 – 1,219.16	956.05 – 1,470.83	1,119.63 – 1,722.49	1,283.21 – 1,974.16	1,446.80 – 2,225.83	B
715.84 – 894.79	967.50 – 1,209.37	1,219.17 – 1,523.95	1,470.84 – 1,838.54	1,722.50 – 2,153.12	1,974.17 – 2,467.70	2,225.84 – 2,782.29	C
894.80 – 1,002.16	1,209.38 – 1,354.49	1,523.96 – 1,706.83	1,838.55 – 2,059.16	2,153.13 – 2,411.49	2,467.71 – 2,763.83	2,782.30 – 3,116.16	D
1,002.17 – 1,109.54	1,354.50 – 1,499.62	1,706.84 – 1,889.70	2,059.17 – 2,279.79	2,411.50 – 2,669.87	2,763.84 – 3,059.95	3,116.17 – 3,450.04	E
1,109.55 – 1,216.91	1,499.63 – 1,644.74	1,889.71 – 2,072.58	2,279.80 – 2,500.41	2,669.88 – 2,928.24	3,059.96 – 3,356.08	3,450.05 – 3,783.91	F
1,216.92 – 1,324.29	1,644.75 – 1,789.87	2,072.59 – 2,255.45	2,500.42 – 2,721.04	2,928.25 – 3,186.62	3,356.09 – 3,652.20	3,783.92 – 4,117.79	G
1,324.30 – 1,431.73	1,789.88 – 1,935.09	2,255.46 – 2,438.45	2,721.05 – 2,941.81	3,186.63 – 3,445.17	3,652.21 – 3,948.53	4,117.80 – 4,451.88	H

If you begin receiving social security disability benefits, whether or not your income changes, you must notify Basic Health. This may affect your eligibility for Basic Health. Please also refer to the following list when sending income information to Basic Health.

Include **income from the following sources:**

- Salaries, wages, commissions, tips, and work study income
- Self-employment and rental income
- Unemployment income and strike benefits
- Social security benefits and Supplemental Security Income
- Retirement and pensions
- Child support, family support, and alimony
- Insurance benefits
- Income from interest, including interest on IRA distributions, dividends, trusts, annuities, and royalties
- Veterans' benefits and military allotments
- Labor and Industries benefits
- Public assistance (Department of Social and Health Services cash assistance)
- Estate income, gambling/lottery winnings
- Other income if not listed under "Do not include"

Do *not* include:

- Income, such as wages, earned by dependent children
- Capital gains
- Any assets drawn down as withdrawals from a bank, or proceeds from the sale of property, such as a house or car
- Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for any injury (except workers' compensation)
- Income from a family member who lives in another household, when that income is not available to you or eligible dependents seeking Basic Health enrollment
- University scholarships, grants, fellowships, or assistantships
- Non-cash benefits (such as food stamps, school lunches, or housing assistance)
- Payments for adoption support received from the Department of Social and Health Services

Reporting income changes. Please send the *Monthly Income Worksheet* (included in the back of this handbook), along with:

- Copies of your family's pay stubs and proof of gross income (before taxes) from all sources for the entire month or last 30 days; and
- A copy of your federal income tax return for the most recent year (W-2 forms are not acceptable). Regardless of whether you filed by mail or electronically, your federal income tax return must be signed by you (your tax preparer's signature is not sufficient). If you were not required to file or do not have a copy of your tax

return for the most recent year, you must send a transcript of your account (showing gross interest income and self-employment income) or Verification of Nonfiling Status, which you can request from the IRS by calling 1-800-829-1040.

- A *Self-Employment/Rental Income Worksheet*, if required. For additional information or to see if you need to send this form, read the instructions with the worksheet in the back of this handbook.

Basic Health will notify you of how your change in income may affect your monthly premium or eligibility. This notice, called a "personal eligibility statement," may explain that you have an additional premium due. Please review it carefully.

Income averaging. If your income (other than self-employment/rental income) varies greatly from month to month, and the variation is not the result of a change in source of income, Basic Health can determine your premium based on an average of your income over three months. To request income averaging, send a written request to Basic Health, along with the required documentation of your income for the most recent three months and your signed federal income tax form (IRS Form 1040) or tax transcript for the most recent year. The premium that is set based on average income will be "locked in" for six months, unless there is a major change in your family circumstances during that time (such as a gain or loss of a job, or marriage or divorce) or all Basic Health premiums change.

Self-employment or rental income. If you are reporting self-employment or rental income, Basic Health will require that your premium be based on an average of your income, using a 12-month history of your self-employment or rental income and expenses, unless you have had the business or rental property for less than 12 months.

Family changes

(Full-premium members: Please refer to page 24.)

You may add eligible family members to your Basic Health account during open enrollment, if you meet income guidelines. At other times during the year, you may enroll family members only if your status changes because of:

- Marriage (application must be received at Basic Health within 30 days of the marriage, even if your new spouse is not applying for coverage).
- Birth or adoption (application must be received by Basic Health within 60 days of the birth or placement of the child).
- Loss of other continuous coverage for which you previously either left Basic Health or waived Basic Health coverage (application must be received by Basic Health within 30 days of the loss and you will be required to provide proof of continuous coverage).
- Change in legal custody of a child or disabled dependent (application and proof of legal custody or guardianship must be received by Basic Health within 30 days of the custody change).

To enroll a new family member, please call 1-800-842-7712 to request the *Family Changes Form* or visit Basic Health's Web site. Be sure to follow the instructions included with the form. You will need to send Basic Health current documentation of family income, as well as any other income changes that could affect your monthly premium.

If you do not provide the necessary form or documentation within the time frames stated above, the new family member will be added to your account for family size only (which may change your monthly premium), but cannot enroll until the next open enrollment period.

To add a newborn or newly adopted child, you may also use the detachable *Change Form* included with your monthly billing statement.

Page 5 describes when coverage begins for new family members. Please note that Basic Health's reduced-premium program can enroll only a certain number of people. If we reach that limit, Basic Health may be required to delay your coverage.

Separation or divorce. To take action on your account due to separation or divorce, please call 1-800-842-7712 to request a *Family Changes Form* or visit Basic Health's Web site. Be sure to follow the instructions included with the form. You will need to send Basic Health current income information and proof of residency. If there are children on your account, you will also need to send a copy of the court order determining a parent's custody or obligation to provide for the child's health care coverage.

When you notify Basic Health of a change in family size that could also change your income (such as a marriage, divorce, or death), you will be required to submit proof of your current income.

Address changes

If you move, call Basic Health immediately at 1-800-660-9840, complete the detachable *Change Form* included with your billing statement and return it with your payment, or write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683. Include your subscriber I.D. number, your name, new address and county, your old address, and your phone number. Be sure to say if your new address is permanent or temporary (less than six months), and if your mailing address is different from your street address.

If you move within Washington State, or your address changes, you must provide Basic Health with your new address **within 30 days**. If you move out of your health plan's service area, you will be required to select a new health plan. Until your coverage can be transferred to a health plan that serves the area where you live, you will need to travel to the area served by your old health plan for any services except emergency services.

Please note: We routinely verify addresses with the U.S. Postal Service, so please be sure to file a change of address with your post office, as well.

Changing health plans

(Full-premium members: Please refer to page 24.)

During open enrollment, you may change your health plan (if you have more than one plan available in your area) or enroll eligible family members as long as you meet income and eligibility requirements. Basic Health will send you open enrollment materials, which will indicate the effective date of these changes and provide information on available health plans and the monthly premium for each. You'll be notified of each upcoming open enrollment period and given instructions for making changes.

Other than during open enrollment, you will not be allowed to change health plans unless you are able to show "good cause" for the change. An example of what would be considered "good cause" is moving to a county where your current health plan is not offered. It is not considered good cause for a change in health plans if your doctor or other provider is no longer participating with your health plan.

When you are given an opportunity to change health plans, remember that each health plan contracts with different providers and has its own prescription drug formulary (list of covered drugs). You should call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription medications, you also should contact the health plan you are considering to see if your medications will be covered.

If you change health plans, any services you had approved under your previous health plan may need to be approved again by your new health plan. Check with your health plan for further information.

Basic Health *Plus* and Maternity Benefits Program

Enrollees have the right to change enrollment prospectively, from one health plan to another, without cause, each month.

Basic Health for Groups

If you are enrolled in a group account, make sure your employer or sponsor is aware of any changes in your income or family circumstances; either you or your employer or sponsor must notify us of those changes.

If you are enrolled in a group account through your employer, a change in your income or family size may affect the amount you are required to contribute toward your coverage. Contact your employer or payroll officer if you have questions about those changes.

If you are no longer eligible for employer, home care agency, or financial sponsor group coverage and you still meet income guidelines, Basic Health will offer you coverage under an individual account and you will be required to pay the premium for your continued coverage.

If you are transferring from an individual account to a group account, or vice versa, contact Basic Health to notify us of the change.

Disenrollment and re-enrollment

How to disenroll

(Full-premium members: Please refer to page 24.)

You may disenroll from Basic Health or Basic Health *Plus* coverage for yourself, a family member, or your entire family at any time by notifying Basic Health by phone at 1-800-660-9840, or in writing (P.O. Box 42683, Olympia, WA 98504-2683). The notification must include:

- Your name and Basic Health subscriber I.D. number;
- The name of each person you are disenrolling;
- Reason for disenrolling (especially if due to other insurance, Medicare, or Medicaid); and
- The month you want coverage to end. Coverage will end the last day of the month you indicate, but no sooner than the next coverage month. To qualify for a refund of your premium payment, we need to receive your request to disenroll at least 10 days before the first of the month the payment was to have covered.

If you voluntarily disenroll from coverage, any remaining family members may continue with Basic Health. Remaining family members enrolled in Basic Health *Plus* or the Maternity Benefits Program through DSHS may stay with that program as long as they are eligible, even if your coverage is suspended or you are disenrolled from Basic Health for failing to pay your required premium.

You may not remain enrolled in Basic Health if you:

- Move out of Washington State (or leave the state for more than six months in a row);
- Become eligible for Medicare (either free or purchased Medicare coverage).
- Have income above Basic Health's income guidelines and do not live in a county served by a health plan accepting enrollment in Basic Health's full-premium program.
- Do not pay the required premium when due, or your employer or financial sponsor does not pay the required premium when due. In addition, if your coverage is suspended more than two times

in a 12-month period, you and your family members will be disenrolled from Basic Health and will not be allowed to re-enroll for at least 12 months.

- Do not pay the amount due for recoupment of a subsidy overpayment by the due date (see "Recoupment" on page 7).
- Engage in any form of fraud against Basic Health or your health plan or its providers, or knowingly provide false information.

You also may be disenrolled from Basic Health if you:

- Pose a risk to the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors.
- Refuse to accept or follow procedures or treatment recommended by your PCP and determined by your health plan's medical director to be essential to your health (or the health of your child), and you have been told by your health plan that no other treatment is available.
- Have repeatedly failed to pay copayments on time.

The above conditions for loss of eligibility also apply to family members enrolled on your Basic Health account.

If your coverage ends, you'll receive a written notice describing the reason and the date your coverage will end.

Basic Health *Plus*

If your child is no longer eligible for Basic Health *Plus* (for example, due to age or a change in income or family status), you will receive notice from Basic Health or DSHS. To request that your child's enrollment be continued under Basic Health, you must respond to Basic Health within 30 days of that notice.

Basic Health for Groups

When your employer coverage ends, you may have a choice of continuing coverage through COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) or becoming an individual member of Basic Health. Under COBRA, you would be able to continue your coverage for up to 18 months; however, you would have to pay the full cost of your coverage, including any premium share that had been paid by your employer. Contact your employer directly to find out if you are eligible for COBRA coverage. Basic Health may also offer you individual coverage.

How to re-enroll

Re-enrollment procedures depend on the reason your coverage ended and the time since you last had coverage. At the time you re-apply for Basic Health, you may be required to submit a new application, new documentation of income and residency, and proof of other continuous coverage. Because Basic Health enrollment is limited, you may have to wait until space is available before you can re-enroll.

Generally, when you disenroll from Basic Health, you will be required to wait 12 months before you can re-enroll. However, the wait for re-enrollment will be waived if:

- You left for other coverage, and you re-apply for Basic Health within 30 days of losing other continuous coverage (you will be required to provide proof of continuous coverage); or
- You move out of the state, then move back and establish residency; or
- You were disenrolled because you were no longer eligible for reduced-premium Basic Health coverage, and no health plan offered Basic Health full-premium coverage in your county, but you have now become eligible for coverage.

Chapter Four: What's Covered?

Covered services and supplies

The listing of services covered under Basic Health, called the "Schedule of Benefits," is contained in Appendix A of this handbook. If you have questions about a particular medical condition or Basic Health benefit, contact your health plan directly at the number listed on the inside front cover of this handbook.

Basic Health *Plus* and Maternity Benefits Program

Basic Health *Plus* and Maternity Benefits Program-covered services and supplies are the same as those through the DSHS Medicaid program. A complete listing of covered services and supplies is located in Appendix B. In addition to all Basic Health-covered services and supplies in Appendix A*, Basic Health *Plus* and the Maternity Benefits Program cover:

- Dental services.
- Medically necessary durable medical equipment, such as wheelchairs and hospital beds.
- Vision services (including eye exams or eyeglasses).
- Speech therapy, occupational therapy, and expanded physical therapy.

Please note: Basic Health *Plus* and Maternity Benefits Program members will not be charged copayments or missed appointment fees.

Your child may receive vision care or dental services from any DSHS-participating provider who is willing to treat him or her. You can go to your primary care provider for a referral for vision or dental services if you wish, but you are not required to do so. Your health plan will cover the other services only as specified in Appendix B, and only if you have a referral from your PCP. If your child has reached your health plan's limits for one of these services, you may be able to get additional help through other DSHS programs. For more information on covered services and limits, call the Medical Assistance Customer Service Center at 1-800-562-3022.

Pre-existing condition waiting period

- If you did not have similar coverage in the three-month period prior to your application or enrollment, you must wait **nine** months from the day your coverage begins before Basic Health will cover pre-existing conditions (as defined below), except for maternity care and prescription drugs.
- If you had health care that was similar to Basic Health at any time during the three months just before you applied for or were enrolled in Basic Health, your waiting period for treatment of a pre-existing condition may be waived or shortened as described in "Limitations and exclusions," page 34.
- A pre-existing condition is defined as an illness, injury, or condition for which, in the **six** months immediately preceding a member's effective date of enrollment in Basic Health:
  - Treatment, consultation, or a diagnostic test was recommended for or received by the member; or
  - Medication was prescribed or recommended for the member; or
  - Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

*Basic Health *Plus* covers some services differently than Basic Health. Please refer to Appendix B for more information.

For all members:

- You must be enrolled in Basic Health for 12 months in a row before you will be covered for organ transplant procedures for a pre-existing condition. Further information on the waiting period for organ transplant procedures is provided in the Basic Health "Schedule of Benefits" on page 29.

Basic Health *Plus* and Maternity Benefits Program

There is no pre-existing condition requirement for children covered under Basic Health *Plus* or for pregnant women enrolled in the Maternity Benefits Program.

If you need emergency care

Emergency care is covered 24 hours a day, seven days a week. (For additional information, including a definition of "emergency," refer to page 30 of this handbook.) To receive benefits from your health plan for emergency care, it is important to follow these steps:

- Depending on the severity of the problem, go directly to the nearest emergency room, call 911, or call your primary care provider.
- If you are admitted to a hospital or other health care facility, call (or have a friend, family member, or staff member call) your health plan or primary care provider within 24 hours or as soon as is reasonably possible.
- See (or be referred by) your primary care provider for follow-up care.

Important: If you do not follow these instructions, your coverage for emergency services may be limited to the amount that would have been paid if you had notified your PCP. (See "Emergency Care" on page 30.) You are responsible for paying any balance. If the case is determined not to be an emergency (whether or not you follow the instructions), you will be responsible for all costs.

If you are pregnant

(Full-premium members: Please refer to page 25.)

If you become pregnant, call 1-800-660-9840 right away to notify Basic Health of your pregnancy.

We will mail a Basic Health *Maternity Benefits Application* for you to complete. The Maternity Benefits Program is a Medicaid program jointly administered with the Department of Social and Health Services' (DSHS) Medical Assistance Administration (MAA). The program allows you to receive maternity benefits through the same health plan you choose for your Basic Health coverage. When you are choosing a provider for your maternity services, you should always verify that the provider contracts with your chosen health plan to provide Maternity Benefits Program services through Basic Health.

DSHS determines eligibility for the Maternity Benefits Program based on Medicaid eligibility criteria. (Medicaid will require a written verification of the pregnancy from a licensed doctor, nurse, or medical laboratory, and will ask for an estimated due date. Home pregnancy tests are not accepted for proof of pregnancy.)

Basic Health provides coverage for maternity services for only 30 days after your doctor verifies your pregnancy, unless you apply for the Maternity Benefits Program. So, you must submit your Basic Health *Maternity Benefits Application* within 30 days after your pregnancy is verified to continue maternity coverage. If you do not apply for the Maternity Benefits Program, you will be responsible for the full costs of any maternity services received more than 30 days after your pregnancy is verified.

The Medical Assistance Administration will tell you if you are or are not eligible for the Maternity Benefits Program. Once your enrollment in the Maternity Benefits Program is complete, you will not have monthly premiums or copayments, and you will continue to receive your care through your Basic Health health plan. However, you will need to continue paying your Basic Health premiums until the effective date of your enrollment in the Maternity Benefits Program. Your enrolled family members will still be covered through Basic Health, and you will still be responsible for paying premiums for them.

If you do not meet citizenship requirements, you may be eligible for other Medical Assistance programs that cover maternity care. To receive these benefits through other Medical Assistance programs, you must report your pregnancy to Basic Health and provide written verification of your pregnancy.

If you have completed the application process for the Maternity Benefits Program and submitted all the required documentation, but you have been told you are not eligible for DSHS maternity benefits, Basic Health will cover maternity services you receive while you are enrolled in Basic Health. However, before these costs will be paid, Basic Health must receive a copy of your denial notice from the Medical Assistance Administration.

The Maternity Benefits Program allows you to receive other services often referred to as "First Steps." First Steps coverage includes maternity support services such as childbirth education classes and support, as well as child care and transportation for medical appointments. See the "Schedule of Benefits" (Appendices A and B) for details about differences between Basic Health and Medical Assistance benefits.

When your pregnancy ends

Once your pregnancy ends, it is very important that you notify Basic Health at 1-800-660-9840 right away. An application to add your newborn child to your Basic Health account will be mailed to you. To avoid a break in coverage, Basic Health must receive your completed application for your newborn's coverage within 60 days of the child's birth.

Your medical coverage will resume under Basic Health at the end of your maternity benefits coverage only if your family's Basic Health premiums (if any) have been paid while you were enrolled in the Maternity Benefits Program. For example, if you have a spouse and/or dependent(s) enrolled in Basic Health and they are disenrolled for nonpayment while you are covered through the Maternity Benefits Program, your coverage will continue until the end of your pregnancy. However, at that point, you will lose your coverage, and you and your family (except for children enrolled in Basic Health *Plus*) will not be able to re-enroll in Basic Health until 12 months from the date of your family's disenrollment. In addition, if enrollment limits have been reached, you will be required to wait until space is available for you to re-enroll in the reduced-premium program.

Basic Health *Plus*

If your child is pregnant, or thinks she might be, she should see her primary care provider right away. Once her pregnancy is verified, you must notify Basic Health at 1-800-660-9840.

When your child's pregnancy ends

You must also notify Basic Health at the end of the pregnancy. Newborns are covered under the dependent mother's Basic Health *Plus* coverage until 60 days after birth and are automatically eligible for continued Basic Health *Plus* coverage for the first year of life, (as long as the mother was covered by Basic Health *Plus* at the time of birth). To continue the newborn's Basic Health *Plus* coverage, you must send notice to Basic Health within 60 days of the date of birth (use the *Family Changes Form* or the *Change Form* included with your billing statement). To continue Basic Health *Plus* coverage for her newborn, your child may also need to enroll under her own account.

Please note: Even though you must notify Basic Health of the pregnancy, your child does not need to apply for additional maternity benefits coverage if she is covered under Basic Health *Plus*. Her maternity services will be covered through Basic Health *Plus*.

The right to exercise conscience

Religiously sponsored health plans, health care providers, or employers have the right not to provide benefits or services for termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your health plan or employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another provider, with no added cost to you. Contact your health plan for more information.

If you object to having coverage for termination of pregnancy or other services, you may notify Basic Health in writing. Benefits will not be provided to you for those services; however, your premium will not change.

Chapter Five: Common Problems

What if I receive a bill for covered services?

If you receive care from a doctor or other provider who contracts with your health plan, the provider will usually bill the health plan directly. However, you may receive a bill from a provider who does not contract with your health plan, or from a provider who did not know about your Basic Health coverage. (When you fill out information for your provider, be sure to list the health plan that provides your coverage–not just Basic Health.) If you receive a bill for services that you think are covered by Basic Health, send the bill directly to your health plan at the address on your I.D. card. (Call your health plan at the number listed in the front of this book for details.) Benefits may be denied if your health plan receives the bill more than 12 months after the date you received services. If you have questions about whether the services are covered, call your health plan.

Basic Health *Plus*

If you receive a bill for your children's services:

- Send the bill directly to your health plan at the address on your I.D. card; and
- Call DSHS at the phone number on your M.A.I.D. card.

What do I do if a third party is responsible for my injury or illness?

You or your representative are required to notify your health plan if your provider charges the health plan for treatment of an injury or illness that is the result of another person's or organization's action or failure to act (for example, a fall, an auto accident, or an accident at work). The other person or organization responsible for your injury or illness is called the "third party."

You must notify your health plan promptly, in writing, of all of the following:

- The facts of the injury or illness, including the name and address of any third party you think may be responsible for the injury or illness;
- The name and address of the third party's insurance company, if they are insured;
- The name and address of attorney(s) who will be representing the third party;
- If you plan to file a claim or lawsuit against the third party, the name and address of the person who will be representing you;
- Adequate advance notice of any trial, hearing, or possible settlement of your claim against the third party;
- Any changes in your condition or injury; and
- Any additional information reasonably requested by the health plan.

If you bring a claim or legal action against a liable third party, you must seek recovery of the benefits paid by your health plan.

After you have been fully compensated for all damages you experienced as a result of the accident, your health plan has a right to reimbursement up to the amount of the benefits the health plan has paid, from any recovery you receive. You are required to pay the health plan only the amount that is left over after you have been fully compensated for all of your damages (including pain and suffering and lost wages), up to the amount of the benefits paid.

If your health plan seeks to recover benefits directly from the third party, you must cooperate fully and must not do anything to impair your health plan's right of recovery. Your health plan may bring suit

against the third party in your name, or may join as a party in a lawsuit or claim you have filed. Your health plan will not be required to pay for legal costs you incur, and you will not be required to pay legal costs incurred by your health plan. However, your health plan may agree to share the cost if they choose to be represented by your attorney.

You could be disenrolled from Basic Health for "intentional misconduct" if you:

- Withhold from your health plan information you have about a legally responsible "third party;" or
- Refuse to help your health plan collect from that legally responsible "third party."

How do I file a complaint or appeal?

If you have a complaint or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find their toll-free number on the inside front cover of this book. If you have a complaint about an action taken by Basic Health, call 1-800-660-9840. If you speak to a representative from Basic Health or your health plan, it is helpful if you note the date of the call, the name of the representative, and whether the representative was with Basic Health or your health plan.

Complaints or disputes with your health plan

Your health plan is required to provide you information on its complaint/appeal process when you enroll, when you report a complaint, and with the health plan's notice of an appeal decision.

If you disagree with a decision made by your health plan (such as denial of a claim or benefits interpretation) or have a complaint regarding your health plan's services, providers, or facilities, you must follow your health plan's procedures for resolving disputes. Basic Health staff are available to help you resolve the issue informally, but the matter cannot be appealed to Basic Health. If you file a complaint against a health plan service, provider, or facility, state law limits the information the health plan may provide you regarding the resolution.

If you file a complaint or appeal with your health plan, the health plan must respond within 14 days of receiving it. This response may be a decision or notification of a reason for a delay. However, unless you agree to an additional delay, the decision may not be delayed more than 30 days after the health plan receives your appeal. If waiting for a decision could jeopardize your health, make sure the health plan is aware of that so they can deliver a decision more quickly. Issues that would jeopardize your health must be decided within 72 hours of receiving the appeal.

If you have exhausted your health plan's complaint/appeal process and disagree with the health plan's decision, or if your health plan has not responded to your request within 30 days, you have the right to request a review of the decision by an independent review organization. This can also be done through your health plan. Your health plan is required by law to provide the independent review organization with all information on which the decision was based within 3 business days of receiving the request. You may also be required to provide additional information or documentation needed for the independent review organization's decision.

Complaints or disputes with Basic Health

If you have a complaint or want an explanation of an action taken on your account, write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683, or call toll-free 1-800-660-9840. A representative will try to resolve your issue.

If you disagree with a Basic Health decision, such as a denial of eligibility, premium, premium adjustment or penalty, change of health plan, or loss of Basic Health membership, you may file a written appeal with Basic Health within 30 days of the notice of the decision. Write to Basic Health Appeals, P.O. Box 42690, Olympia, WA 98504-2690, stating you want to file an appeal. Your letter must include your name, address, Basic Health subscriber I.D. number, a daytime phone number, and a summary of the decision you are appealing and why you believe the decision was incorrect. You should also include any evidence that will help explain or prove that the decision should be changed.

You may ask to explain in person or by phone why you believe the decision was incorrect and should be changed. Be sure to let us know if you will need an interpreter and, if so, what language and dialect you speak.

Within five days of receiving your letter, Basic Health will send written confirmation that your appeal was received. If you have asked for a chance to explain your appeal over the phone or in person, our Appeals Department will contact you to schedule a conference. The conference will be recorded to ensure an accurate record, and you will be questioned as well as given an opportunity to explain your point of view. You should be prepared to give detailed information to support your opinion that the decision was in error.

Your appeal will be reviewed carefully, and Basic Health will mail a written notice of the decision to you within 60 days of receiving your appeal. If additional time is required for investigation of your appeal, you'll be notified in writing and a decision date will be set.

If you disagree with Basic Health's decision on your appeal, you may request a review of that decision by writing to: Basic Health Appeals, P.O. Box 42690, Olympia, WA 98504-2690. Basic Health must receive your letter within 30 days of the date on the notice of Basic Health's appeal decision. In your letter, you should explain that you are requesting a review of Basic Health's appeal decision. Also include a summary of the decision you are contesting, why you believe the decision was incorrect, any information not included in your original appeal that you believe needs to be considered, and a daytime phone number where we can reach you.

The Office of Administrative Hearings will review Basic Health's appeal decisions regarding disenrollment due to nonpayment. A presiding officer from the Health Care Authority will review Basic Health's appeal decisions on all other issues, based on the record of the appeal and any evidence you send. Be sure to include all information you want considered. The presiding officer may contact you for further information. The HCA will notify you in writing of the final decision.

Basic Health *Plus* and Maternity Benefits Program

If you have concerns about your maternity care or your child's treatment or care, follow the steps below.

- Talk to your (or your child's) PCP.
- If you still have a problem, call your health plan and ask to file a complaint (the phone number is on the inside front cover of this book).
- If you cannot solve the problem, call DSHS at 1-800-794-4360 (TTY/TDD users: call 1-800-461-5980).
- If you have a problem not solved by your health plan's complaint/appeals procedure, or if you feel you are not getting the health care you need, you have the right to a DSHS fair hearing. To ask for a fair hearing, call the Fair Hearing Coordinator at your DSHS Community Service Office, or contact the:

  Office of Administrative Hearings
  P.O. Box 42489
  Olympia, WA 98504-2489
  1-800-583-8271

CHAPTER SIX:
Full-Premium Program

In some instances, Basic Health's full-premium program is different from the reduced-premium program. This chapter explains which sections do not apply, and the differences for full-premium members for 2002.

For 2002, Basic Health's full-premium program is not open to **new applicants.**

Family changes

(amends page 12)

The "Family changes" section on page 12 **does apply** to members of the full-premium program, with the **following exception**: Family members who didn't enroll when the rest of the family enrolled, or who didn't enroll within the time allowed for family status changes (marriage, birth, adoption, etc.) cannot enroll. They have missed their opportunity and will not be given this option during open enrollment.

Changing health plans

(amends page 13)

The "Changing health plans" section on page 13 does not apply to members of Basic Health's full-premium program. Full-premium members must remain with their current health plan throughout 2002. If you move out of the area served by your health plan, your coverage will end at the end of the next coverage month.

Loss of eligibility for the full-premium program

(amends page 14 and 15)

The "How to disenroll" section on pages 14 and 15 **does apply** to full-premium program members. **In addition**, you will be disenrolled if no health plan is offering full-premium coverage in the area where you live, or if you move out of your current health plan's service area.

If you are disenrolled because no health plan offered full-premium Basic Health in your area, and you later become eligible to enroll in reduced-premium coverage or another Basic Health program, you will not be required to wait 12 months to re-enroll.

Income changes

(amends pages 10 and 11)

The following information is **in addition to** the section on "Income changes" on pages 10 and 11. If your income decreases enough that you are within our income guidelines, you may be eligible to transfer from the full-premium program to reduced-premium coverage. Check the income guidelines in *How Much Will Basic Health Coverage Cost?* or call 1-800-660-9840 for further information. Income guidelines are also available on our Web site, *www.wa.gov/hca/basichealth*. If you believe you are eligible for the reduced-premium program, send us proof of all family income for the most recent 30 days, along with a signed copy of your federal tax return and any schedules for the most recent year. After review of your income information, Basic Health will notify you of your eligibility for the reduced-premium program.

Covered benefits

(amends Appendix A)

Read the "Covered services" and "Copayments" sections in Appendix A. These same benefits apply to full-premium members, with the exception of copayments and maternity benefits, as indicated below.

Maternity care. Maternity benefits listed on page 28 **are covered**. Full-premium members are not required to submit a denial notice from the Medical Assistance Administration in order to receive these benefits.

Copayments. The table below amends information in Appendix A, page 33, for full-premium members.

Covered service	Your copayment
Physician	
Age 18 and under:	$15 for office or home visit.
Over age 18:	$25 per office or home visit.
Maternity care:	No copayment.
Hospital	If a member's hospital stay continues into the succeeding calendar year, copayments for the new calendar year will not apply for that hospital stay.
Age 18 and under:	$100 **per day**, up to $500 maximum per member per calendar year; no copayment for readmission for the same condition within 90 days.
Over age 18:	$200 **per day**, up to $1,000 maximum per member per calendar year; no copayment for readmission for the same condition within 90 days.
Maternity care:	Maternity care is subject to the copayment.
Outpatient facility	
Non-emergency:	$75 per non-emergency outpatient admission or facility visit; no copayment for readmission for the same condition within 90 days. Maternity care is subject to the copayment.
Emergency:	$75; waived if an inpatient admission results.
Lab and x-ray	No copayment.
Ambulance	$75. No copayment when the health plan requires a member to transfer from a non-contracting facility to a contracting facility, or when transfer to and from a facility is required for the member to receive necessary services.
Preventive care	No copayment.
Maternity care	Copayment applies for inpatient and outpatient facility. No copayment for office or home visit.
Pharmacy	Tier 1: $10 Tier 2: $20 Tier 3: 50%

APPENDIX A: Schedule of Benefits

This "Schedule of Benefits" lists benefits for Basic Health members who meet income guidelines.

If you are a member of Basic Health's full-premium (nonsubsidized) program, be sure to read Chapter Six of this handbook. It will explain the differences between the information in this handbook and the full-premium program.

Services are subject to all provisions of this "Schedule of Benefits," including limitations, exclusions, and copayments. Except as specifically stated otherwise, all services and benefits under Basic Health must be provided, ordered, or authorized by the health plan or its contracting providers. Even if your provider authorizes a service, your health plan may also need to preauthorize the care.

If you have a question about the benefits listed, or are not sure if a service is covered, you should call the health plan's customer service department.

I. Coverage criteria

Members have the right to receive the services outlined in this "Schedule of Benefits" from their health plan when all of the following four coverage criteria are met.

A. The service is required because of a disease, illness, or injury, and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.

B. There is sufficient evidence to indicate that the service will directly improve the length or quality of the member's life. Evidence is considered to be sufficient to draw conclusions if it is peer-reviewed (as defined by the National Association of Insurance Commissioners), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.

C. The service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.

D. The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the member which is more conservative or substantially less costly.

II. Covered services

The following services are covered when coverage criteria are met:

A. Hospital care

The following hospital services are covered:

1. Semi-private room and board, including meals; private room and special diets; and general nursing services.

2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room when eligible for Basic Health maternity benefits, anesthesia, radiology, laboratory and other diagnostic services.

3. Normal newborn care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, nursery and laboratory services.

4. Drugs and medications administered while an inpatient.

5. Special duty nursing.

6. Dressings, casts, equipment, oxygen services, and radiation and inhalation therapy.

If a member is hospitalized in a non-contracting facility, the health plan has the right to require transfer of the member to a contracting health plan facility at the health plan's expense, when the member's condition is sufficiently stable to enable safe transfer.

If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Personal comfort items such as telephone, guest trays, and television are not covered.

B. Medical and surgical care

The following medical and surgical services are covered. The health plan may require that certain medical and surgical services be provided on an outpatient basis.

1. Surgical services.

2. Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.

3. Dressings, casts, and use of cast room; anesthesia and anesthesia-related oxygen services.

4. Blood, blood components and fractions (such as plasma, platelets, packed cells, and albumin), and their administration.

5. Provider visits, including diagnosis and treatment in the hospital, outpatient facility, or office; consultations, treatment, and second opinions by the member's PCP, or by a referral provider. Normal newborn care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, routine newborn exams and laboratory services.

   Pharmaceuticals that are or would normally be an intrinsic part of a provider visit (inpatient or outpatient) are covered as part of the provider visit.

6. Radiation therapy; chemotherapy.

7. Inpatient and outpatient chiropractic and physical therapy services are covered to a combined maximum of six (6) visits per calendar year, and are covered for only post-operative treatment of reconstructive joint surgery when received within one year following surgery. Diagnostic or other imaging procedures solely for determination of therapy services are not covered. Chiropractic services may be referred or self-referred to contracted providers.

8. Prescription drugs and medications as defined in "Pharmacy benefit."

9. Family planning services provided by the member's PCP or women's health care provider. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps, and long-acting progestational agents) determined most appropriate by the PCP or women's health care provider for use by the member are also covered. Over-the-counter supplies such as condoms and spermicides are covered only when part of a health plan protocol at the health plan's discretion. Elective sterilization is covered.

C. Maternity care

(Full-premium members: Please refer to page 25.) For pregnant reduced-premium Basic Health members who are determined to be eligible for medical assistance through the Department of Social and Health Services (DSHS), Basic Health shall only cover maternity care services for a period not to exceed 30 days following diagnosis of pregnancy.

The following maternity care services are covered for members who are determined to be ineligible for medical assistance through the DSHS: diagnosis of pregnancy; full prenatal care after pregnancy is confirmed; delivery; postpartum care; care for complications of pregnancy; preventive care; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; medications; anesthesia; normal newborn care following birth, such as but not limited to, nursery services and pediatric exams; and termination of pregnancy (including voluntary termination of pregnancy).

D. Chemical dependency

Members are eligible to receive residential and outpatient chemical dependency treatment from a health plan-contracting approved treatment program to a maximum benefit of $5,000 in a 24 consecutive calendar month period up to a lifetime benefit maximum of $10,000. Covered residential and outpatient treatment includes services such as diagnostic evaluation and education, and organized individual and group counseling. The hospital copayment applies to intensive inpatient services. Outpatient copayments for residential (other than intensive inpatient) and intensive outpatient services shall not exceed the hospital stay copayment. Health plans may use lower copayments, if applicable, for group sessions. Court-ordered treatment will be covered only if determined by the health plan to meet coverage criteria.

In determining the $5,000 limit, the health plan reserves the right to take credit for chemical dependency benefits paid by any other group medical plan on behalf of a member during the immediate preceding 24 consecutive calendar month period. In determining the $10,000 lifetime limit, the health plan reserves the right to take credit for chemical dependency benefits paid under Basic Health on behalf of the member from January 1, 1988.

E. Mental health services

Mental health services are covered as follows:

Inpatient care in a participating hospital or other appropriate, licensed facility approved by the health plan is covered in full (subject to copayment) up to 10 days per calendar year.

Outpatient care, including individual and family counseling, is covered in full up to 12 visits per calendar year after the copayment per visit for individual sessions. Health plans may use lower copayments, if applicable, for group sessions. Visits for the sole purpose of medication management are exempted from the 12-visit limit, and are instead covered as other provider visits.

Court-ordered treatment will be covered only if determined by the health plan to meet coverage criteria.

F. Organ transplants

Services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care, are covered. This benefit includes covered donor expenses.

Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, cornea, kidney, and kidney-pancreas human organ transplants are covered when coverage criteria are met.

Organ transplant recipient: All services and supplies related to the organ transplant for the member receiving the organ, including transportation to and from a health plan-designated facility (beyond that distance the member would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the member has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ transplant donor: The donor's initial medical expenses relating to harvesting of the organ(s), as well as the costs of treating complications directly resulting from the procedure(s), are covered, provided the organ recipient is a member of the health plan, and provided the donor is not eligible for such coverage under any other health care plan or government-funded program.

Waiting period: Members must be enrolled in Basic Health for 12 consecutive months before they can receive benefits for transplant procedures. The waiting period applies to the transplant procedure including any immediate pre- and post-operative hospital care related to the transplantation, but does not apply to ongoing follow-up care including prescription drugs.

If a member satisfies the 12 consecutive month waiting period (no breaks in coverage for 12 consecutive months) and subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

The waiting period will not apply:

1. If the transplant is required due to a condition which is not a pre-existing condition;
2. For children enrolled in and continuously covered by Basic Health from birth; or,
3. For children placed in the home for purposes of adoption within 60 days of birth and continuously covered by Basic Health from the date of placement, provided one or both of the adoptive parents or family members are enrolled in Basic Health at the time of placement in the home.

If a newborn child enrolled from birth, or a newborn-adoptive child enrolled within 60 days of placement, subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

Limitations: Transplants that are not preauthorized or are not performed in a health plan-designated medical facility are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

All services are subject to the appropriate copayment at the time of service.

G. Emergency care

An emergency is a sudden or severe health problem that needs treatment right away; there is not time to talk to your doctor.

"Emergency" is defined as:

> "The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy."

The health plan reserves the right to determine whether or not the symptoms indicate a medical emergency. Acute detoxification is covered for up to 72 hours.

1. **In-service-area emergency**. In the event a member experiences a medical emergency, care should be obtained from a health plan-contracting provider. If, as a result of such emergency, the member is not able to use a health plan-contracting provider, the member may obtain such services from non-contracting health care providers. Follow-up care must be provided or approved by the health plan. In the case of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within twenty-four (24) hours of admission, or as soon thereafter as is reasonably possible. Failure to meet the notification requirements will result in coverage limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.

2. **Out-of-service-area emergency**. The health plan shall bear the cost of out-of-service-area emergency care for covered conditions. In the event of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within twenty-four (24) hours of admission, or as soon thereafter as is reasonably possible. Failure to meet the notification requirements will result in coverage limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.

   The health plan may, at its discretion, appoint a consultant when out-of-service-area care is necessary, who will have authority to monitor the care rendered and make recommendations regarding the treatment plan. The health plan may otherwise secure information which it deems necessary concerning the medical care and hospitalization provided to the member for which payment is requested.

3. **Transfer and follow-up care**. If a member is hospitalized in a non-contracting facility, the health plan reserves the right to require transfer of the member to a health plan-contracting facility, when the member's condition is sufficiently stable to enable safe transfer. If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Follow-up care which is a direct result of the emergency must be obtained from a health plan-contracting provider, unless a health plan-contracting provider has authorized such care in advance.

4. **Prescription drugs.** Prescription drugs purchased from a non-contracting facility or pharmacy are covered subject to the applicable pharmacy copayment when dispensed or prescribed in connection with covered emergency treatment.

5. **Emergency ambulance transportation.** Medically necessary ambulance transportation is covered in an emergency, or to transfer a member when preauthorized by the health plan.

H. Skilled nursing and home health care benefits

As an alternative to hospitalization in an acute care facility, the health plan, at its discretion, may authorize benefits for the services of a skilled nursing facility or home health care agency.

I. Hospice services

Hospice services are covered.

J. Plastic and reconstructive services

Plastic and reconstructive services (including implants) will be provided:

1. To correct a physical functional disorder resulting from a congenital disease or anomaly;

2. To correct a physical functional disorder following an injury or incidental to covered surgery; and

3. For a member who is receiving benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses (internal and external) and physical complications of all stages of mastectomy.
- Treatment of lymphedemas is covered; however, durable medical equipment and supplies used to treat lymphedemas may be covered only in limited circumstances. Please contact your health plan for specific coverage information.

K. Preventive Care

Preventive care services are covered, and will be provided as described in the schedule provided to you by the health plan.

L. Pharmacy benefit

(Full-premium members: Please refer to page 25.)

The health plan may limit the drugs available through use of a list called a "formulary." Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determine that no formulary drugs are an acceptable medication for the patient. If you have a question about the benefits listed, are not sure if a drug is covered, or believe a nonformulary drug should be covered, you should call the health plan's customer service department for information.

Basic Health covers drugs (of all types, including prescribed creams, ointments, and injections) at the copayment levels shown.

Prescriptions are limited to a 30-day supply.

Tier 1	Tier 2	Tier 3
Copayment: $3	**Copayment: $7**	**Copayment: 50%**
Covered Drugs: (Examples) Amoxicillin Clotrimazole vaginal cream Co-Trimoxazole Diphenhydramine Doxycycline Erythromycin base Erythromycin ethylsuccinate Insulin Metronidazole Nystatin (oral or topical) Permethrin Prenatal vitamins	Covered Drugs: Generic drugs contained in the health plan's formulary, except those included in Tier 1. All oral contraceptives in the health plan's formulary. Syringes and needles Diabetic test strips Lancets	Covered Drugs: Brand-name drugs in the health plan's formulary.

Drugs for cosmetic purposes are excluded unless preauthorized.

M. Additional services

Services in addition to those listed in this "Schedule of Benefits" may be provided by the health plan, at the sole discretion of the health plan, subject to copayments and limitations. You will not be required to accept these additional services as a condition of enrollment in Basic Health, or to pay any additional premium for such additional services.

III. Copayments

(Full-premium members: Refer to page 25.)

The member is responsible for paying any required copayment directly to the provider of a covered service unless instructed by the health plan to make payment to another party. Copayments must be paid in full at the time of service, or service may be denied or rescheduled.

Only those copayments specifically listed below are to be charged to members for covered services. Members may be charged a missed appointment fee by a provider if they continually fail to keep appointments, or if they repeatedly fail to give timely notice when it is necessary to cancel appointments.

Covered service	Your copayment
Physician	$10 per office or home visit; no copayment for maternity care.
Hospital	$100 per inpatient admission, $500 maximum per member per calendar year; no copayment for maternity care, or readmission for the same condition within 90 days.
Outpatient facility	
Non-emergency	$25 per non-emergency outpatient admission or facility visit; no copayment for maternity care, or readmission for the same condition within 90 days.
Emergency	$50; waived if an inpatient admission results.
Lab & x-ray	No copayment.
Ambulance	$50; no copayment when the health plan requires a member to transfer from a non-contracting facility to a contracting facility, or when transfer to and from a facility is required for the member to receive necessary services.
Preventive care	No copayment.
Maternity care	No copayment. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered only through the Department of Social and Health Services.
Pharmacy (See "Pharmacy benefit" for types of drugs covered in each tier.)	Tier 1: $3 Tier 2: $7 Tier 3: 50%

IV. Limitations and exclusions

A. Limitations

1. Preexisting condition waiting period

(a) A preexisting condition is defined as: "Any illness, injury, or condition for which, in the six (6) months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member, or
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment."

(b) **Waiting period**

Basic Health will not provide benefits for services or supplies rendered for any preexisting condition during the first nine (9) consecutive months following the member's effective date of coverage. A member will not be required to begin a new nine (9) consecutive-month waiting period if:

- Coverage is suspended for not longer than one (1) month during the waiting period, and
- The member does not have more than two (2) one-month breaks in coverage during the waiting period.

Coverage for preexisting conditions will not be available until the member is actually covered by Basic Health for a total of nine (9) months.

If the member is confined in a health care facility for treatment of a preexisting condition at the time the member's nine (9) month waiting period ends, benefits for that condition will be provided only for covered services rendered after the end of the waiting period.

(c) **Exceptions to waiting period**

(i.) The following services are not subject to the waiting period:

- Maternity care.
- Prescription drugs as defined in "Pharmacy Benefit."

(ii.) Children born on or after the parent's and/or sibling's effective date of coverage who are enrolled within 60 days of the date of birth, and adopted children who are acquired after the adoptive parent's and/or sibling's effective date of coverage who are enrolled within 60 days of physical placement with the adoptive parents, are not subject to the nine (9) month waiting period for preexisting conditions.

(d) **Credit toward the waiting period**

Credit toward the waiting period will be given for:

- The length of delay in enrollment up to a maximum of three (3) months when, due to Basic Health budgetary constraints, enrollment is delayed for applicants who have otherwise completed the enrollment process and have been determined to be eligible for enrollment.

- Any continuous period of time for which a member was covered under similar health coverage if:

  - That coverage was in effect at any time during the three (3) month period immediately preceding the date of reservation or application for coverage under Basic Health, or within the three (3) month period immediately preceding enrollment in Basic Health; and

  - The coverage terminated not later than the first of the month following the effective date of coverage in Basic Health.

If similar coverage was in effect both prior to the date of application or reservation and the date of enrollment, credit will be given for the longer period of continuous coverage.

"Similar coverage" includes Basic Health; all DSHS programs administered by the Medical Assistance Administration which have the Medicaid scope of benefits; the DSHS program for the medically indigent; Indian Health Services; most coverages offered by health carriers; and most self-insured plans.

2. Major disaster or epidemic. If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.

3. The benefits available under Basic Health shall be secondary to the benefits payable under the terms of any health plan which provides benefits for a Basic Health member except where in conflict with Washington State or federal law.

B. Exclusions

The services listed below are not covered:

1. Services that do not meet coverage criteria for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.

2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.

3. Services received before the member's effective date of coverage.

4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial

care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.

6. Emergency facility services for nonemergency conditions.

7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.

8. Transportation except as specified under "Organ transplants" and "Emergency care."

9. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.

10. Sex change operations; investigation of or treatment for infertility or impotence; reversal of sterilization; artificial insemination; and in vitro fertilization.

11. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care;" and hearing aids.

12. Orthopedic shoes and routine foot care.

13. Speech and occupational therapy.

14. Medical equipment and supplies not specifically listed in this "Schedule of Benefits" (including but not limited to hospital beds, wheelchairs, walk aids, respiratory equipment, and oxygen) except:

    a) While the member is in the hospital, or

    b) When a provider contracted with the member's health plan requests prior approval of a service, supply, or equipment. The health plan may limit approval to those situations where, in its sole judgment, it is expected that coverage will result in a lower, total out-of-pocket cost to the health plan if the member were to stay in Basic Health and the health plan for a subsequent four (4) years.

15. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.

16. Obesity treatment; weight loss programs.

17. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."

18. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with the Revised Code of Washington or federal law; the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.

19. Conditions resulting from acts of war (declared or not).

20. Direct complications arising from excluded services.

21. Any service or supply not specifically listed as a covered service, unless prescribed by a contracting provider and authorized by the health plan.

C. Changes to covered services and premiums

The Basic Health Administrator may from time to time revise this "Schedule of Benefits." In designing and revising this "Schedule of Benefits," the Administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary basic health care services, as well as the cost to members and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

The HCA will provide you with written notice of any planned revisions to Basic Health premiums or the benefit plan at least 30 days prior to the effective date of the change. This notice may be included with your premium statement, open enrollment materials or other mailing, or may be a separate notice. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first-class postage paid, directed to you at the mailing address on file with the HCA.

APPENDIX B:
Schedule of Benefits for Basic Health *Plus* and Maternity Benefits Program

Note: In this portion of the document, the "Contractor" is your health plan. The "Department" refers to the Washington State Department of Social and Health Services.

I. Covered Services:

A. The Contractor shall cover the services described in this Section when medically necessary. The amount and duration of covered services that are medically necessary depends on the enrollee's condition.

B. Except as specifically provided herein, the scope of covered services shall be comparable to the Medical Assistance Administration's (MAA) Medicaid fee-for-service program. For specific covered services, this shall not be construed as requiring the Contractor to cover the specific items covered by MAA under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

C. Enrollees have the right to self-refer for certain services to providers paid through separate arrangements with the State of Washington. The Contractor is not responsible for the coverage of the services provided through such separate arrangements. The enrollees also may choose to receive such services from the Contractor. The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department, family planning facility, or Regional Support Network (RSN) for such services up to the limits described herein. The services to which an enrollee may self-refer are:

1. Outpatient mental health services to community mental health providers of the Regional Support Network (RSN) for Prepaid Health Plan.
2. Family planning services and sexually-transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.
3. Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.
4. Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency are covered when those services are otherwise covered services.

D. Inpatient Services:
Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18-51) when nursing facility services are not covered by the Department's Aging and Adult Services Administration and the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

E. Outpatient Hospital Services:
Provided by acute care hospitals (licensed under RCW 70.41).

F. Emergency Services: All inpatient and outpatient services that are provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider, which are necessary to evaluate and stabilize an emergency medical condition.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 USC 1396u-2(b)(2)(c)).

Emergency services shall be provided without requiring prior authorization.

Services provided when the PCP or other plan representative has instructed the enrollee to seek emergency services, regardless of whether the enrollee's condition meets the prudent layperson standard.

If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor.

Any post-stabilization services, related to the admitting diagnosis, up to the point of discharge, that the Contractor has either:

1. Authorized
2. Failed to authorize because the Contractor did not respond within thirty (30) minutes to a request for authorization for post-stabilization services (RCW 48.43.093(d))
3. Failed to authorize due to circumstances beyond the emergency department's control

G. Ambulatory Surgery Center:
Services provided at ambulatory surgery centers.

H. Provider Services:
Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians.

Provider Services include, but are not limited to:

- Medical examinations, including wellness exams for adults and Early Periodic Screening and Diagnostic Testing (EPSDT) for children
- Immunizations
- Maternity care
- Family planning services provided or referred by a participating provider or practitioner
- Performing and/or reading diagnostic tests
- Private duty nursing
- Surgical services
- Surgery to correct defects from birth, illness, or trauma, or for mastectomy reconstruction
- Anesthesia
- Administering pharmaceutical products
- Fitting prosthetic and orthotic devices
- Rehabilitation services
- Enrollee health education

- Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia
- Nutritional counseling when referred as a result of an EPSDT exam

I. Tissue and Organ Transplants:
Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell.

J. Laboratory, Radiology, and Other Medical Imaging Services:
Screening and diagnostic services and radiation therapy.

K. Vision Care:
Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

L. Outpatient Mental Health:

1. Psychiatric and psychological testing, evaluation and diagnosis:
   a. Once every twelve (12) months for adults twenty-one (21) and over
   b. Unlimited for children under age twenty-one (21) when identified in an EPSDT visit
2. Unlimited medication management:
   a. Provided by the PCP or by PCP referral
   b. Provided in conjunction with mental health treatment covered by the Contractor
3. Twelve hours per calendar year for treatment
4. Transition to the RSN, as needed to assure continuity of care, when the enrollee has exhausted the benefit covered by the Contractor or when enrollee request such transition
5. Referrals To and From the RSN:
   a. The Contractor shall cover mental health services provided by the RSN, up to the limits described herein, if the Contractor refers an enrollee to the RSN for those services.
   b. The Contractor may, but is not required to, accept referrals from the RSN for the mental health services described herein.
6. The Contractor may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the Contractor. Such agreements shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.
7. The DSHS Mental Health Division (MHD) and MAA shall each appoint a Mental Health Care Coordinator (MHCC). The MHCCs shall be empowered to decide all Contractor and RSN issues regarding outpatient mental health coverage that cannot be otherwise resolved between the Contractor and the RSN. The MHCCs will also undertake training and technical assistance activities that further coordination of care between MAA, MHD, Healthy Options contractors and RSNs. The Contractor shall cooperate with the activities of the MHCCs.

M. Occupational Therapy, Speech Therapy, and Physical Therapy:
Services for the restoration or maintenance of a function affected by a enrollee's illness,

disability, condition or injury, or for the amelioration of the effects of a developmental disability.

N. Pharmaceutical Products:
Prescription drug products according to a Department approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in MAA's fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet medically necessary health needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request.

Covered drug products shall include:

1. Oral, enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas
2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products
3. Antigens and allergens
4. Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

O. Home Health Services:
Home health services through Medicare-certified, state-licensed agencies.

P. Durable Medical Equipment (DME) and Supplies:
Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years or age; and medical supplies.

Q. Oxygen and Respiratory Services:
Oxygen, and respiratory therapy equipment and supplies.

R. Hospice Services:
When the enrollee elects hospice care.

S. Blood, Blood Components and Human Blood Products:
Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products the Contractor shall cover the cost of the blood or blood products.

T. Treatment for Renal Failure:
Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

U. Ambulance Transportation:
The Contractor shall cover ground and air ambulance transportation for emergency medical conditions, as defined in Section F, Emergency Services, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

1. When it is necessary to transport an enrollee between facilities to receive a covered services; and,
2. When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

V. Chiropractic Services:
For children when they are referred during an EPSDT exam.

W. Neurodevelopmental Services:
When provided by a facility that is not a DSHS recognized neurodevelopmental center.

X. Smoking Cessation Services:
For pregnant women through sixty (60) days post pregnancy.

II. Exclusions:

The following services and supplies are excluded from coverage. This shall not be construed to prevent the Contractor from covering any of these services when the Contractor determines it is medically necessary.

A. Services Covered By MAA Fee-For-Service Or Through Selective Contracts:

- School Medical Services for Special Students as described in the MAA billing instructions for School Medical Services.
- Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.
- Voluntary Termination of Pregnancy, including complications.
- Transportation Services other than Ambulance: Taxi, cabulance, voluntary transportation, public transportation.
- Dental Care, Prostheses and Oral Surgery, including physical exams required prior to hospital admissions for oral surgery.
- Hearing Aid Devices, including fitting, follow-up care and repair.
- First Steps Maternity Case Management and Maternity Support Services.
- Sterilizations for enrollees under age 21, or those that do not meet other federal requirements.
- Health care services provided by a neurodevelopmental center recognized by DSHS.
- Certain services provided by a health department or family planning clinic when a client self-refers for care.
- Inpatient psychiatric professional services.
- Pharmaceutical products prescribed by any provider related to services provided under a separate agreement with DSHS or related to services not covered by the Contractor.
- Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division.
- Protease Inhibitors
- Services ordered as a result of an EPSDT exam that are not otherwise covered services.
- Gastroplasty
- Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. Genetic services beyond Prenatal Diagnosis Genetic Counseling are covered as maternity care when medically necessary, see Section H, Provider Services.
- Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when approved by DSHS in accord with WAC 388-531.

B. Services Covered By Other Divisions In The Department Of Social And Health Services:

- Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA), including

inpatient detoxification services for alcohol (3-day) and drugs (5-day) with no complicating medical conditions.

- Nursing facility and community based services (e.g. COPES and Personal Care Services) covered through the Aging and Adult Services Administration.
- Mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, and inpatient psychiatric services. This shall not be construed to prevent the Contractor from purchasing covered outpatient mental health services from community mental health providers.
- Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

C. Service Covered By Other State Agencies:

Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

D. Services Not Covered by Either DSHS or the Contractor:

- Medical examinations for Social Security Disability.
- Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.
- Physical examinations required for obtaining continuing employment, insurance or governmental licensing.
- Experimental and Investigational Treatment or Services, services associated with experimental or investigational treatment or services.

  The policies and prodecures and any criteria the contractor uses to determine that a service is experimental or investigational, will be provided to you, by your contractor, at your request.
- Reversal of voluntary surgically induced sterilization.
- Personal Comfort Items, including but not limited to guest trays, television and telephone charges.
- Biofeedback Therapy.
- Diagnosis and treatment of infertility, impotence, and sexual dysfunction.
- Orthoptic (eye training) care for eye conditions.
- Tissue or organ transplants that are not specifically listed as covered.
- Immunizations required for international travel purposes only.
- Court-ordered services.
- Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody.
- Any service, product, or supply paid for by MAA under its fee-for-service program only on an exception to policy basis. The Contractor may also make exceptions and pay for services it is not required to cover under this agreement.
- Any other service, product, or supply not covered by MAA under its fee-for-service program.

APPENDIX C:
A Guide to Terms Used in This Handbook

BASIC HEALTH
A health coverage program administered by the Health Care Authority (HCA).

BASIC HEALTH *PLUS*
A Medicaid program jointly administered with the Department of Social and Health Services (DSHS) Medical Assistance Administration for children under age 19 from low-income families. It provides expanded benefits (such as dental and vision care) and has no premiums or copayments. Eligibility for Basic Health *Plus* is determined by DSHS, based on Medicaid eligibility criteria.

CERTIFICATE OF COVERAGE
A description of your health care coverage and benefits. This handbook serves as your certificate of coverage.

CONTRACTOR
In Appendix B, refers to the health plan that provides Basic Health *Plus* or Maternity Benefits Program coverage.

COPAYMENT
The portion of an expense you pay when you receive care.

DSHS
Department of Social and Health Services. The state agency which administers Medicaid and (along with the Health Care Authority) jointly administers Basic Health *Plus* and the Maternity Benefits Program.

DEPENDENT
Same as family members.

DISENROLLMENT (FOR NONPAYMENT)
The process of losing Basic Health coverage due to nonpayment by the due date given in the notice of suspension or because of more than two suspensions in a 12-month period.

ENROLLMENT
The process of submitting completed application forms, being determined eligible, and being accepted into Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.

FAMILY MEMBERS
Family members who should be listed as dependents on your account include your:

- Spouse (unless legally separated)
- Your or your spouse's unmarried children, whether by birth, adoption, legal guardianship, or placement pending adoption, who are:
  - Under age 19; or
  - Under age 23, if full-time students at an accredited school.
- Legal dependent, of any age, who is incapable of self-support due to disability.

FIRST STEPS
Medicaid coverage designed to reduce maternal and infant illness and death, as well as increase access to maternity and infant care. Pregnant women eligible for DSHS medical assistance are eligible to receive First Steps services.

FORMULARY
An approved list of prescription drugs developed by each health plan.

Full-premium program
Basic Health's health coverage program in which members pay the full cost of their monthly premium, based on the Health Care Authority's contracted rates with managed care plans.

Health Care Authority (HCA)
The state agency responsible for Basic Health administration and coordinating with DSHS to provide Basic Health *Plus* and the Maternity Benefits Program.

Health plan
An organization that offers health care coverage and contracts with the HCA to provide your care. You choose your health plan when you join Basic Health. Appendix B refers to the health plan as the "Contractor."

Income
Your wages and salaries; tips; interest; dividends; royalties; public or private pensions; social security benefits; Labor & Industries (L&I) and Department of Social and Health Services (DSHS) grants; child support; unemployment compensation; net income from rentals or self-employment; and any other income as defined by Basic Health.

Income band
Income levels A through H, as listed in the *How Much Will Basic Health Coverage Cost?* brochure. These levels, based on gross monthly income and family size, help determine monthly premiums.

Income guidelines
The guidelines used to determine your eligibility for Basic Health and Basic Health *Plus*, and your monthly premium payments for Basic Health coverage. These income guidelines change annually. Refer to the *How Much Will Basic Health Coverage Cost?* brochure for more information.

Inpatient
A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maternity Benefits Program
The program coordinated with DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity benefits, maternity support services, and maternity case management. Eligibility for the program is determined by the DSHS Medical Assistance Administration, based on Medicaid eligibility criteria.

Medicaid
The federal aid program which provides medical coverage for persons in the DSHS categorically needy and medically needy programs.

Medical Assistance Administration (MAA)
A unit of DSHS that is authorized to administer medical care. MAA and Basic Health jointly administer Basic Health *Plus* and the Maternity Benefits Program.

Medicare
The federal health benefit program for people who are ages 65 and over, and for some people with disabilities. (If you are eligible for free or purchased Medicare coverage, you are not eligible for Basic Health.)

Member
A person enrolled in Basic Health, Basic Health *Plus*, or the Maternity Benefits Program, and receiving coverage.

Outpatient
A nonhospitalized patient receiving covered services away from a hospital such as in a physician's office or the patient's own home, or in a hospital outpatient or hospital emergency department.

Personal eligibility statement (PES)
The notice Basic Health sends you, showing the current status of your account. **You will receive a PES each time there is a change to your account.** This statement may include a bill for additional premiums you must pay as a result of a change.

Physician Incentive Plan (PIP)
Any conpensation arrangement between a Medicaid contractor and a physician or physican group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of the Medicaid contract

Premium
Your monthly payment for Basic Health coverage.

Premium "lock-in"
The period of time for which a member's premium will not change, unless the member has a qualifying change of circumstances (such as a job change, marriage, or divorce) or all Basic Health premiums change (such as with a new contract year). Premiums are "locked in" when a member's income has been calculated using income averaging.

Primary care provider (PCP)
Your personal provider. Your primary care provider can be a family or general practitioner, internist, pediatrician, or other provider approved by your health plan. To receive benefits, your primary care provider must provide or coordinate your care. If you need to see a specialist, your primary care provider will refer you.

Provider
A health care professional (such as a doctor, nurse, internist, etc.) or facility (such as a hospital, clinic, etc.).

Recertification
Periodic review of members' income and eligibility. During recertification, members are required to submit current income and residency documentation to verify their eligibility and/or level of premium subsidy.

Recoupment
When Basic Health bills a member for any premium subsidy overpaid because the member failed to accurately report income or income changes.

Reduced-premium program
Basic Health's health coverage program that offers members a lower-cost monthly premium, with the state paying a share of the monthly premium. The member's income must be less than the Basic Health income guidelines (based on their family size) to be eligible for the reduced-premium program.

Service area
The geographic area served by a health plan that is providing coverage for Basic Health members.

Specialist
A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Student
A person enrolled full-time in an accredited secondary school, college, university, technical college, or school of nursing, as determined by the school registrar.

Subscriber
The person on a Basic Health account who is responsible for payment of premiums and copayments and to whom Basic Health sends all notices and communications. The subscriber may be a Basic Health member or the spouse, parent, or legal guardian of an enrolled dependent.

Suspension of coverage (for nonpayment)
The process of losing health coverage for a period of one month after a monthly premium has not been paid or has been paid after the due date. If your coverage is suspended more than two times in a 12-month period, you will be disenrolled and cannot re-enroll for at least 12 months.

Tier
A category of drugs related to the pharmacy benefit. Your cost for prescriptions depends on the category (or tier) the prescription falls within. (For example, Tier 1 is in the category of prescriptions that costs you the least.)

Washington resident
A person physically residing and maintaining an abode in the state of Washington.

Income Worksheets

- Monthly Income Worksheet
- Self-Employment/Rental Income Worksheet

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MONTHLY INCOME WORKSHEET

Follow the instructions beginning on page 3. If you have rental or self-employment income, you may also be required to fill out the *Self-Employment/Rental Income Worksheet* on the other side of this form.

❑ Check here if you want your monthly Basic Health premium based on the most recent three consecutive months' income. Be sure to attach proof of each source of income for all three months. Read page 3 of the instructions.

Do not send original documents. They cannot be returned to you.

Income source	Income received	Family member who received this income:	Send a copy of:
Wages, salary, commissions, or tips for the most recent 30 days or full calendar month	$		Pay stubs. (If your pay stub does not show the amount you received as tips, include a signed and dated statement from your employer, indicating the amount you earned in tips.)
Self-employment or rental profit or loss, if applicable (from your IRS Form 1040 or line 32 of the *Self-Employment/Rental Income Worksheet*) UBI number:	$		Your most recently filed federal income tax return (IRS Form 1040) and all applicable schedules. (If you were not required to file a tax return or are asking us to use less than 12 months of information, complete and send the *Self-Employment/Rental Income Worksheet*.)
Unemployment compensation	$		Check stubs.
L&I (workers' compensation)	$		Award letter showing your current gross monthly benefits.
Child support, family support, alimony	$		◗ Checks; ◗ Court documents indicating the amount awarded; ***or*** ◗ Office of Support Enforcement (DSHS) statement.
Social security or supplemental security income	$		Benefits statement received at the beginning of the current year.
Public assistance (includes DSHS grants)	$		Copy of the award letter showing your monthly benefit and dates received.
Retirement income or pension	$		◗ Pay stub; ***or*** ◗ Award letter or benefit statement showing your current monthly benefit. ◗ Military cost of living allotment statement.
Other (please describe; see instructions with this application)	$		Read the instructions to find out what to send.
Subtotal:	$		
Subtract work-related dependent care expenses (see instructions):	—$		Receipts, canceled checks, or credit card invoices for work-related dependent care expenses, or the child support order showing the amount for child care expenses and the canceled check covering the most recent month. Include the name, address, and phone number of the dependent care provider.
Total gross monthly income:	$		IRS Form 1040 and schedules, or transcript or proof of nonfiling status (see the instructions).

If you or your spouse are reporting no income, you must briefly state how you supported yourself and then sign below.

Signature	Name (please print or type)	Date
		/ /
Signature of spouse	Name (please print or type)	Date
		/ /

HCA 24-301 (10/00)

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SELF-EMPLOYMENT/RENTAL INCOME WORKSHEET

Not everyone is required to complete this section. Read page 5 of the instructions to see if you need to fill in this information.

1 Check one: ❑ Self-employment income ❑ Rental income

2 Business name		3 UBI number
4 Business address	City State ZIP Code	
5 Type of business		6 Taxpayer I.D. or social security number

7 Indicate the months you are reporting on this form: MO / YR – MO / YR	**COLUMN I** Total for most recent 30 days or full calendar month (must be completed for Basic Health *Plus* or Maternity Benefits Program)	**COLUMN II** Total for period you are reporting	**COLUMN III** Average per month
INCOME			**A**
8 Gross receipts, sales, or rental income	$	$	$
EXPENSES			
9 Merchandise and materials	$	$	$
10 Gross wages paid to employees	$	$	$
11 Employer's payroll-related taxes	$	$	$
12 Advertising/other promotional expenses	$	$	$
13 Car and truck expenses	$	$	$
14 Commissions/management fees	$	$	$
15 Depreciation	$	$	$
16 Insurance	$	$	$
17 Interest – mortgage	$	$	$
18 Interest – other	$	$	$
19 Legal and professional services	$	$	$
20 Rent or lease – vehicles, machinery, or equipment	$	$	$
21 Rent or lease – other business property	$	$	$
22 Repairs and maintenance	$	$	$
23 Supplies	$	$	$
24 Taxes	$	$	$
25 Travel	$	$	$
26 Meals and entertainment	$	$	$
27 Utilities	$	$	$
28 Other expenses	$	$	$

29 **Total average monthly expenses** *Add expense totals from lines 9 through 28 in column III, and enter in B.*	— $ **B**
30 **Average monthly self-employment profit (or loss)** *Subtract B from A, and record in C.*	$ **C**
31 **Your share of profit (or loss)** Form of business: ❑ Sole proprietorship ❑ Partnership ❑ S-Corporation	Percentage of business you own % **D**
32 Your share of average monthly self-employment/rental profit (or loss) *Multiply C by D and record here and on the Monthly Income Worksheet under "self-employment or rental profit or loss."*	$

Monthly Income Worksheet Instructions

Fill out this section to report all gross family income, from all sources, before taxes. Gross family income includes all income received by you and any listed dependents, regardless of whether they're enrolled in Basic Health.

General Instructions – Monthly Income Worksheet

For each line, show all your household's gross income received during the last 30 consecutive days or complete calendar month and fill in the name of the person who received that income. Enter the actual dollar amount (rounded to the nearest dollar), or "0" on each line.

If you or a dependent received several months' income during a single month, you may divide that income by the number of months for which the income was received. Example: You receive a $5,000 check from the Social Security Administration in October to cover your disability benefits for the months of June through October (5 months). Your monthly income from that source is $1,000 ($5,000 ÷ 5 = $1,000 per month).

Attach the documentation listed under the "Send a copy of:" column. **Do not send original documents; they cannot be returned to you.** All income documentation must show the date the income was received, the period for which it was earned, and the recipient's name and/or social security number. If you cannot obtain the required income documentation, send a signed, dated statement that includes the name of the person paid, the payment dates, the income source, and the payment amount before taxes or other deductions.

In addition to the documentation listed under the "Send a copy of:" column, attach a signed copy of your most recently filed federal income tax return (IRS Form 1040 and all attachments you filed with it). Whether you filed by mail or electronically, you must have signed the IRS form (your tax preparer's signature is not sufficient). If you didn't have to file or don't have a copy of your tax return for the most recent year, attach a transcript of your account or verification of nonfiling status. You can request these from the IRS by calling 1-800-829-1040 or by taking form 4506 to your local IRS office.

Line-by-Line Instructions – Monthly Income Worksheet

Income Averaging ("Check here if you want...")

If your income changes enough from month to month to change your premium (generally, about $200 a month), you may want to check this box to request that your last three months' income be averaged. **If you are applying for Basic Health *Plus* or the Maternity Benefits Program, DSHS will determine eligibility using income documentation for the most recent month only.** If your income is averaged, your premium will not change for six months unless all Basic Health premiums change or your individual circumstances change (for example, you lose your job or your family size changes).

Wages, salary, commissions, tips

Fill in the amount for each adult family member. Do not include earned income for children.

Self-employment or rental profit or loss

Fill in the net profit or loss from self-employment or rental income. Use the amount shown on your federal income tax return, unless you are completing the *Self-Employment/Rental Income Worksheet* (see instructions for that section to find out if you need to complete it). If you complete the *Self-Employment/Rental Income Worksheet*, transfer the amount from line 32 of that section to the second line of this worksheet. Be sure to attach a signed copy of your IRS Form 1040 for the most recent year, including all schedules you filed, unless you weren't required to file. Fill in your Unified Business Identifier (UBI) number, from your Washington Master License.

Unemployment compensation

If you recently lost your job and received unemployment compensation, indicate the amount actually received within the most recent 30 days or calendar month. If this will not accurately reflect your income, send updated income documentation after you are enrolled.

L&I (workers' compensation)

Fill in the monthly amount you were awarded, before any deductions.

Child support, family support, alimony

Do not include payments from the Department of Social and Health Services (DSHS) adoption support program.

Social security or supplemental security income (SSI)

Fill in the monthly amount you were awarded, before any deductions.

Public assistance (includes DSHS grants)

This includes any financial assistance you receive from DSHS or other public assistance, other than adoption support.

Retirement income or pension

If you are reporting an IRA distribution, only show the amount of interest received.

Other
The table on the right shows the most common income sources that may be included here and the documentation to send for each of them.

Subtotal
Add all the figures in the column.

Work-related dependent care expenses
Fill in the total you paid to care for children 12 or younger or for a disabled adult dependent. This is also for the last 30 days or most recent calendar month (limited to $650 a month per dependent for work-related child care). For a disabled adult dependent, be sure to include proof of legal guardianship.

Total gross monthly income
Subtract work-related dependent care expenses from total and fill in that amount here.

"Other" Income	Send a copy of (do not send original documents)
Income from an adult foster home	◗ Your adult foster home license; ◗ Your most recently filed federal tax return (IRS Form 1040) and all applicable schedules; *and* ◗ Social Services Payment System (SSPS) Invoice Voucher. (If you were not required to file a federal income tax form, send the *Self-Employment/ Rental Income Worksheet* completed with your income and expenses for the most recent year.)
Personal care worker wages	Social Service Payment System (SSPS) Service Invoice Voucher.
Stipends or work study	◗ Pay stubs; or ◗ The award letter you received that states what you were paid and for how long.
Annuities	The monthly or quarterly statement from the institution that pays you.
Dividend income	Your statement from the bank or investment firm showing the amount of dividends for the most recent quarter or month.
Estates	Court documents.
Gambling or lottery winnings	Checks.
Insurance (such as life or long-term disability insurance)	The award letter or court documents showing the schedule of payments.
Interest income	Your statement from the bank or investment firm showing the amount of interest for the most recent quarter or month.
Military family allotments	Your Leave and Earning Statement (LES).
Royalties	◗ Checks; or ◗ Contract showing the amount you are paid.
Strike benefits	◗ Check stub showing dates paid and the gross amount paid; or ◗ Signed, dated statement from your union showing the amount paid, before any deductions.
Trusts	Legal trust documents.
Veteran's benefits	Award letter showing your current gross monthly benefits.
Income you cannot otherwise document	Signed and dated statement that includes your name, the date you were paid, the amount you were paid (before any deductions), and the name of the company or person who paid you.

Self-Employment/ Rental Income Worksheet Instructions

Complete this worksheet only if you had self-employment or rental income and:

- You are applying for **Basic Health *Plus* or the Maternity Benefits Program** for a family member (DSHS requires the information in column I for the most recent full calendar month);
- You were **not required to file** a federal income tax return; or
- You are **reporting less than 12 months** of income and expenses (see second paragraph under "General Instructions," below).

Otherwise, you do not need to fill out this worksheet; we will use your IRS Form 1040 and schedules to document your self-employment or rental income. Be sure to include copies of all the schedules you filed, especially schedules A - E, F, K1, and 8582 if they apply to you. Because your current profit (or loss) may have changed since the amount reported on your IRS Form 1040, you may send updated income and expense documentation (such as quarterly tax statements or monthly year-to-date profit/loss statements).

General Instructions – Self-Employment/Rental Income Worksheet

For each line and column, fill in the appropriate dollar amount or "0."

Twelve months of income and expense history are required to determine average monthly profit (or loss). If you have owned the business or rental property for a shorter time, attach a written statement of how long you've owned the business or rental property. Then fill in current monthly income and expenses for the actual number of months you are reporting on this worksheet.

Income history from the *previous* tax year must be based on your IRS Form 1040 (if filing was required) or on historical monthly income and expense documentation.

Income history for the *current* tax year must be based on current income and expense documentation.

All expenses must be related to your business or your rental property. Other expenditures cannot be deducted from your gross family income as expenses.

Column I

Fill in the total for the most recent full calendar month. This is necessary only if you are applying for Basic Health *Plus* or the Maternity Benefits Program for a family member.

Column II

Fill in the total for the number of months you are reporting for the income and expense categories listed.

Column III

Divide the total from column II by the number of months you are reporting to get the average monthly income or expense. Fill in the average.

Line-by-Line Instructions – Self-Employment/Rental Income Worksheet

Line 1

Check the box next to the type of income you're reporting. To report income for more than one type of business or rental, please use separate forms.

Line 2

Write in your name or the name of your business.

Line 3

Fill in your Unified Business Identifier (UBI) number, assigned by the Washington State License Service.

Line 4

Fill in the address of your business. If your business is operated from your home, list your residential address.

Line 5

Include a brief description of the type of business (like gas station, day care, etc.).

Line 6

Fill in your federal taxpayer I.D. number. This is generally your social security number, unless your business is a partnership or a corporation.

Line 7

Fill in the actual months for which you are reporting income and expenses.

Line 8

Fill in the gross income receipts or sales for your business or rental income before any deductions.

Line 9

Fill in the cost of goods sold, including the purchase price of raw materials, shipping, and storage.

Line 10

Do not include payments to yourself, your spouse, or partner(s).

Line 11

Include OASI (social security), Medicare, L&I (workers' compensation), and UI (unemployment insurance) taxes and charges.

Line 12

Fill in your total business or rental advertising or other promotional expenses.

Line 13

Fill in your total car or truck expenses for business-related travel. You may use the actual expense if you have proof that you spent that amount, or the standard mileage rate (36.5 cents per mile for 2000).

Line 14

Fill in your total business or rental commissions, or management fees paid to others.

Line 15
Fill in your annual business or rental depreciation/amortization amount. If you were not required to file an IRS Form 1040, estimate the number of years the equipment/building will be useful. Divide the purchase price by this number of years to determine annual depreciation.

Line 16
Fill in only the costs of insurance directly related to your business or rental activity, such as liability and property insurance. Do not include vehicle insurance costs separately if you used the standard mileage allowance for car and truck expenses (see line 13).

Line 17
Fill in the interest paid on real property mortgages used for your business. *Do not* include amounts paid as repayment of principal. If you use only part of your home (or other property) for business, you must determine the "business percentage" of these expenses. Generally, the business percentage for mortgage interest is the same as the percentage of the property used for business (see line 21).

Line 18
Fill in the interest paid on business-related loans *other than* mortgages. *Do not* include amounts paid as repayment of principal.

Line 19
Fill in your total business- or rental-related legal and professional expenses, such as attorney, accountant, and appraiser fees.

Line 20
Fill in your business- or rental-related expenses for rent or lease of vehicles, machinery, or equipment.

Line 21
Fill in the business- or rental-related expenses for rent or lease of other business property. If the entire property is not used exclusively for business, measure the area of the property in square feet and calculate this by dividing the area of the property used for business by the total area of the property, including the basement. Example: Your property measures 1,200 square feet. You use one room that measures 240 square feet for business. Therefore, you use one-fifth (240 ÷ 1,200), or 20%, of the total area for business.

Line 22
Fill in the business- or rental-related expenses for routine repair and maintenance of your business, equipment, vehicle(s), or rental property. *Do not* include payments for your own labor, or car- and truck-related expenses from line 13.

Line 23
Fill in your business- or rental-related expenses for supplies, such as office supplies, postage, shipping, and handling for your business.

Line 24
Fill in your business- or rental-related *non*payroll taxes, such as property taxes, business and occupational taxes, and business-related license fees. You may list half of the self-employment tax you paid.

Line 25
Fill in business-related travel expenses, which are ordinary and necessary expenses incurred while traveling for your business or profession. *Do not* include expenses listed in line 13.

Line 26
Fill in your business-related expenses for meals and entertainment.

Line 27
Fill in business-related expenses for utilities such as heat, lights, power, and telephone service. List only utility expenses used to support your business. If you use only part of your home (or other property) for business, determine the business percentage of these expenses, generally the same as the percentage of property used for business (see line 21). Example: your electric bill is $400 for lighting, cooking, laundry, and television. Only the lighting bill is used for business. If $250 of your electric bill is for lighting and you use 10% of your property for business, then $25 is considered a business-related expense.

Line 28
Fill in other related business expenses that you will file with your tax return and describe them briefly.

Calculations

Line 29
Add the figures in column III, lines 9 through 28, to determine your total average monthly expenses. Write this amount in box B.

Line 30
Subtract the amount in box B from the amount in box A (at the top of column III) to determine your average monthly self-employment profit (or loss) amount. Write this amount in box C.

Line 31
Check the box next to the appropriate form of business. Determine the percentage of business that you own and write that percentage in box D. If you and your spouse are both partners in the business, this would be the sum of your ownership percentages. Use 100% for a sole proprietorship.

Line 32
Multiply the amount in box C by the percentage in box D to determine your share of the average monthly self-employment/rental net profit (or loss). Transfer this amount to the Monthly Income Worksheet, in the box for "Self-employment or rental profit or loss".)

Keep *Hot Policy Pages* Here

Hot Policy Pages are important updates to this Member Handbook and are one way Basic Health provides you with official notice of program changes; you will receive them periodically, usually with your monthly billing statement. Keep these updates, along with this *Member Handbook* and other information you receive from Basic Health handy, so that you have the information you need to make the most of your Basic Health coverage.

For information on providers available to you and approval of specific services, call your health plan.

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